

<b>Case Number:</b>	CM14-0086238		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	04/20/2013
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	05/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is licensed in Chiropractic and is licensed to practice in New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Upon review of the medical records provided the applicant is a 34 year old male whom sustained an industrial injury on April 20, 2013 while employed by the [REDACTED]. The applicant injured his neck and lower back when lifting heavy furniture. He developed pain, numbness and weakness at the neck and arms. There is a significant past medical history for diabetes mellitus and high blood pressure. Thus far, treatment has consisted of Chiropractic Therapy, Medications including Condrolite, Omeprazole and Tizanidine, Medical Creams, Physical Therapy, Pain Management Treatment, Acupuncture and he underwent surgery on 4/12/13 for a left sided C4 and C5 facet block and left sided C5/6 facet block. MRI of the cervical spine dated 3/4/13 revealed mild multilevel disc degeneration at C3-4 through C5-6, 4mm broad based posterior disc protrusion at C5-6 resulting in severe right and moderate left C5-6 foraminal encroachment with potential impingement on exiting C6 nerve bilaterally, C4-5 3mm disc bulge with a 4 mm far right posterolateral disc protrusion with results in moderate right and mild left C4-5 foraminal encroachment. Electrodiagnostic report dated 6/14/13 revealed a mild left C8 radiculopathy. Sudomotor function report dated 3/7/14 showed abnormal hands and feet symmetry. Upon review of PR-2 form dated 3/7/14 the applicant continued to subjectively complain of intermittent moderate achy neck pain radiating to the hands with numbness, intermittent moderate to severe achy upper/mid back pain, intermittent moderate to severe achy low back pain radiating to the legs with numbness and loss of sleep due to pain. Examination findings revealed tenderness on palpation of the cervical, thoracic, lumbar spine, upper trapezius muscles bilaterally, cervical and lumbar paraspinal musculature. There is muscle spasm noted cervical compression was positive straight leg raise causes pain. At this point in time provided recommended Chiropractic Treatment 1-2 times per week for 6 weeks, Acupuncture 1-2 times per week for 6 weeks, Physical Therapy 1-2 times per week for 6 weeks, X-rays, Functional Capacity Evaluation, Nerve Conduction Velocity testing and medication follow up. The

applicant was diagnosed with cervical, thoracic and lumbar musculoligamentous injury as well as cervical & lumbar radiculopathy and sleep disturbances. Upon review of medical soap notes dated 6/11/14-6/30/14 the applicant continues to present with neck pain that radiates numbness and tingling to bilateral upper extremities associated with weakness of hands constant back pain that intermittently radiates to bilateral lower extremities with numbness & tingling and restless legs at night. There were cervical, thoracic and lumbar myospasms hypertonic muscles and some temporary relief post treatment. Treatment consisted of chiropractic manipulation to the cervical spine and bilateral sacroiliac joints also therapeutic exercise, electrical muscle stimulation, & ultrasound. Upon review of chiropractic services dated 7/18/13-7/25/13 treatment has consisted of hot/cold packs and electrical muscle stimulation and chiropractic manipulation to the left wrist and cervical spinal regions there was no indication as to the applicants' response to these treatments rendered assessment only revealed to continued therapy treatment. In a utilization review dated 5/23/14, the reviewer determined the proposed office visit for electrical stimulation was not certified. The reviewer indicated that although the treatment is determined to be medically necessary the relatedness of the condition to the industrial injury has not been determined. This was based upon the Official Disability Guidelines-Treatment in Workers Compensation Guidelines neck, upper back and lower back procedure summaries indicated that office visits are recommended as determined to be medically necessity with regards to electrical stimulation on 3/10/14. Regarding electrical stimulation and ultrasound therapy on 3/12/14 and 3/14/14, 3/19/14 and 3/21/14, the reviewer referenced the ACOEM Guidelines indicated that treatment modalities include traction ultrasound and TENS have not proven efficacy and were not supported by the guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**Office visit, electrical stimulation therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The applicant is a 34 year old male whom sustained an industrial injury on April 20, 2013 while employed by [REDACTED]. The applicant injured his neck and lower back when lifting heavy furniture. Upon review of chiropractic services dated 7/18/13-7/25/13 treatment has consisted of hot/cold packs, electrical muscle stimulation, chiropractic manipulation to the left wrist and cervical spinal regions. There was no indication as to the applicants response to these treatments rendered, assessment only revealed to continue therapy treatment. Upon review of medical soap notes dated 6/11/14-6/30/14 the applicant continues to present with neck pain that radiates numbness and tingling to bilateral upper extremities associated with weakness of hands, constant back pain that

intermittently radiates to bilateral lower extremities with numbness and tingling and restless legs at night. There were cervical, thoracic and lumbar myospasms hypertonic muscles with temporary relief post treatment. Treatment consisted of chiropractic manipulation to the cervical spine and bilateral sacroiliac joints, therapeutic exercise, electrical muscle stimulation, ultrasound. As per the ACOEM Guidelines, 2nd Edition, 2004, Chapter 12 Low Back page 300 refers to physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation, percutaneous electrical nerve stimulation and biofeedback have no proven efficacy in treatment acute lower back symptoms. As per the ACOEM Guidelines, 2nd Edition, 2004 Chapter 8 neck and upper back complaints, page 173 indicates there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage diathermy, cutaneous laser treatment, ultrasound, TENS units, and biofeedback. These palliative tools may be used on a trial based but should be monitored closely. Emphasis should focus on functional restoration and return patients to activities of normal daily living. There was no indication as the applicants' response to the ultrasound and electrical stimulation treatments rendered. The medical records do not document improvement with this type of treatment and assessment only revealed to continued therapy treatment. Furthermore, it is clear that the treatments rendered did not cause any demonstrative objective functional improvement based upon continued unchanged subjective complaints and examination findings. The requested office visit and electrical stimulation therapy is not medically necessary.

**Manual therapy, electrical stimulation therapy, and ultrasound therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** As per the ACOEM Guidelines, 2nd Edition, 2004, Chapter 12 Low Back page 300 refers to physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation, percutaneous electrical nerve stimulation and biofeedback have no proven efficacy in treatment acute lower back symptoms. As per the ACOEM Guidelines, 2nd Edition, 2004 Chapter 8 neck and upper back complaints, page 173 indicates there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage diathermy, cutaneous laser treatment, ultrasound, TENS units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return patients to activities of normal daily living. There was no indication as the applicants' response to the ultrasound and electrical stimulation treatments rendered. The medical records do not document improvement with this type of treatment and assessment only revealed to continued therapy treatment. Furthermore, it is clear that the treatments rendered did not cause any demonstrative objective functional improvement based upon continued unchanged subjective complaints and examination findings. The requested office visit, electrical stimulation and ultrasound therapy is not medically necessary.

**Electrical stimulation therapy, mechanical traction therapy, and ultrasound therapy:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** As per the ACOEM Guidelines, 2nd Edition, 2004, Chapter 12 Low Back page 300 refers to physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation, percutaneous electrical nerve stimulation and biofeedback have no proven efficacy in treatment acute lower back symptoms. As per the ACOEM Guidelines, 2nd Edition, 2004 Chapter 8 neck and upper back complaints, page 173 indicates there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage diathermy, cutaneous laser treatment, ultrasound, TENS units, and biofeedback. These palliative tools may be used on a trial based but should be monitored closely. Emphasis should focus on functional restoration and return patients to activities of normal daily living. There was no indication as the applicants' response to the ultrasound and electrical stimulation treatments rendered. The medical records do not document improvement with this type of treatment and assessment only revealed to continued therapy treatment. Furthermore, it is clear that the treatments rendered did not cause any demonstrative objective functional improvement based upon continued unchanged subjective complaints and examination findings. The requested office visit, electrical stimulation, mechanical traction and ultrasound therapy is not medically necessary.