

<b>Case Number:</b>	CM14-0208966		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	11/15/2013
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Pennsylvania

Certification(s)/Specialty: Internal Medicine

### CLINICAL CASE SUMMARY

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

The injured worker is a 38-year-old male with a date of injury of 1/15/13. The mechanism of injury was not specified. Diagnoses include thoracic and lumbosacral neuralgia, neuritis, and radiculitis, and lumbar sprain and strain. Treatment has included medications, physical therapy, acupuncture, and activity modification. No results of imaging studies or other diagnostic testing were provided. Acupuncture treatment notes were not provided. An orthopedic report from 8/21/14 notes that the injured worker reported continued pain in the back with radiation into the right posterior thigh, and that the pain has not improved. He reported taking Relafen which helps, and that he has been going to acupuncture and does not think that helps. Pain was rated as 5/10 in severity and constant. Examination showed tenderness in the lumbar paraspinal muscles, straight leg raise 60 degrees on the right and 70 degrees on the left, with normal lower extremity strength. There was pain in the right groin and hip with flexion and rotation, with positive Trendelenburg's sign. Impression was lumbar sprain with possible traction injury, and right hip arthritis. Work status was noted as able to work with restriction of no lifting more than 50 pounds. A magnetic resonance imaging (MRI) arthrogram was requested and Relafen was prescribed. The progress note of 8/21/14 notes that the injured worker denied chest pain, arrhythmias, heart murmurs, any heart ailment, irregular heart beat, shortness of breath, excessive coughing, or asthma. Physical therapy notes from October to December 2014 document that progress was slow but steady and that the injured worker was performing a home exercise program and walking up to one half mile daily. On 11/5/14, a secondary treating physician progress note documents the injured worker complained of frequent 7.5/10 sharp stabbing low

back pain relieved with medication, physical therapy and rest. Examination of the lumbar spine showed reduced range of motion, tenderness to palpation of the sacroiliac (SI) joints, L4-5 and L5-S1 spinous processes and paravertebral muscles and sitting straight leg raise positive. Medications included protonix, norflex, sennosides, norco, and compounded topical creams. Primary treating physician progress note of 12/18/14 documents similar findings, with diagnoses of lumbar radiculopathy and lumbar sprain/strain, and notes requests for acupuncture to increase range of motion and decrease pain/spasm, and orthopedic consult to discuss invasive treatment options. The work status was documented as remain off work until 2/1/15. The request for authorization for the services at issue was not in the documentation submitted. On 11/13/14, Utilization review non-certified requests for diathermy, internal medicine consult to review cardio-respiratory report and recommendations, orthopedic consult, infrared therapy, acupuncture, physical therapy, massage therapy, ultrasound, electrical stimulation/computer assisted electrical muscle stimulation and matrix, therapeutic exercises, and interferential purchase for home use, citing the MTUS and ODG.

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

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

#### **Infrared Therapy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter: Infrared Therapy

**Decision rationale:** The MTUS does not provide direction for infrared therapy. Per the ODG, infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of infrared therapy for treatment of acute low back pain and only if used as an adjunct to exercise. The injured worker has evidence of chronic back pain rather than acute back pain. The request for infrared therapy is not medically necessary.

#### **Acupuncture, with Stimulation, two times per week for four weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Acupuncture Chapter

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site, used to increase the effectiveness of the

needles by continuous stimulation of the acupoint. The documentation indicates that the injured worker has received prior acupuncture. Medical necessity for any further acupuncture is considered in light of functional improvement. Acupuncture treatments may be extended if functional improvement is documented. Acupuncture treatment notes were not provided. There was no documentation of functional improvement as a result of the prior acupuncture treatments. The request for acupuncture with stimulation two times per week for four weeks is not medically necessary.

**Physical Therapy two times per week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 - 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The records do not contain a prescription from the treating physician, which must include treatment modalities. Reliance on passive care is not recommended. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of physical medicine visits is 10, with progression to home exercise. Physical medicine for chronic pain should be focused on progressive exercise and self care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for physical therapy in cases of chronic pain is not sufficient. The injured worker has had prior physical therapy. There was no evidence of symptomatic or functional benefit while the injured worker was in physical therapy previously. The therapy notes that progress was slow but steady, but no measureable improvement in strength or range of motion was documented. There was no documentation of improvement in activities of daily living, reduction in work restrictions, or decrease in dependence on medical treatment. The request for physical therapy, two times per week for four weeks is not medically necessary.

**Massage Therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Massage Therapy Section

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

**Decision rationale:** Per the MTUS, massage therapy should be used as an adjunct to exercise and limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. The physical therapy notes document that the injured worker was performing a home exercise program. However, the request for massage has no specified amount/endpoint, and must be taken as a request for an unlimited or indefinite quantity into

perpetuity. As a result of the lack of a number of treatments being specified, the request for massage is not medically necessary.

**Ultrasound:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ultrasound Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, Therapeutic Page(s): 123.

**Decision rationale:** The MTUS notes that therapeutic ultrasound is not recommended. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating pain or a range of musculoskeletal injuries or for promoting soft tissue healing. The treating physician did not provide a specific indication for the use of ultrasound. In addition, the number of treatments was not specified. As ultrasound treatment is not recommended by MTUS, the request for ultrasound is not medically necessary.

**Electrical Stimulation, computer assisted electrical muscle stimulation and matrix (pulses of energy):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Neuromuscular Electrical Stimulators

**Decision rationale:** Electrotherapy represents the therapeutic use of electricity and is a modality that can be used in the treatment of chronic pain. Transcutaneous electrical nerve stimulation (TENS) devices are the most commonly used; other devices are distinguished from TENS based on their electrical specifications. Most devices other than TENS and H-wave units (in some cases) are not recommended by MTUS. Per the ODG, neuromuscular electrical stimulators (NEMS) are not recommended except for specific criteria which include spinal cord injured patients. Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provide to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The injured worker does not meet these criteria, based on the documentation provided. There is no documentation from the physician of a treatment plan based on functional restoration. The request for Electrical Stimulation, computer assisted electrical muscle stimulation and matrix (pulses of energy) is not medically necessary.

**Therapeutic Exercises:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** Therapeutic exercise is a modality utilized during physical therapy. The injured worker has had prior physical therapy. There was no evidence of symptomatic or functional benefit while the injured worker was in physical therapy previously. The therapy notes that progress was slow but steady, but no measureable improvement in strength or range of motion was documented. There was no documentation of improvement in activities of daily living, reduction in work restrictions, or decrease in dependence on medical treatment. The documentation indicates the injured worker was participating in a home exercise program. The request for therapeutic exercise had no specified amount/endpoint, and must be taken as a request for an unlimited or indefinite number into perpetuity. As a result of the lack of an endpoint to treatment being specified, as well as lack of documentation of functional improvement as a result of prior physical therapy, the request for therapeutic exercise is not medically necessary.

**Interferential Purchase for Home Use:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

**Decision rationale:** Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provide to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The injured worker does not meet these criteria, based on the documentation provided. There is no documentation from the physician of a treatment plan based on functional restoration, and specific indications for the use of a home interferential current stimulation unit were not provided. The request for interferential purchase for home use is not medically necessary.

**Diathermy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Diathermy

**Decision rationale:** Diathermy is a type of heat treatment using either short wave or microwave energy. Per the MTUS, diathermy has no proven efficacy in treating acute low back symptoms. At home applications of heat or cold are as effective as those performed by therapists. The ODG indicates that diathermy is not recommended, as it has not been proven to be more effective than placebo diathermy or conventional heat therapy.

**Internal Medicine Consult to review Cardio-Respiratory report and recommendations:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Office Visits

**Decision rationale:** Per the ODG, office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation submitted did not include a cardio-respiratory report. The progress note of 8/21/14 notes that the injured worker denied chest pain, arrhythmias, heart murmurs, any heart ailment, irregular heart beat, shortness of breath, excessive coughing, or asthma. Due to lack of any documented indications, the request for Internal Medicine Consult to review Cardio-Respiratory report and recommendations is not medically necessary.

**Orthopedic Consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Suffering, And The Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 6), page 112

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): p. 305-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: Office Visits

**Decision rationale:** Per the MTUS, surgery is considered when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disc) is detected. Referral for surgical consultation is indicated for patients who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies, progression of lower leg symptoms, clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit from surgical repair, and failure of conservative symptoms to resolve disabling radicular symptoms. In this case, no imaging or electrophysiologic studies were submitted. The physician progress notes do not document progression of lower leg symptoms or findings. In addition, the injured worker was seen by an orthopedic surgeon and

medical management was recommended. The request for orthopedic consultation is not medically necessary.