

<b>Case Number:</b>	CM15-0046860		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	11/30/2002
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: California  
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 69 year old female, with an industrial injury dated 11/30/2002. The mechanism of injury was not provided for review. Her diagnoses include status post rotator cuff repair (2003), cervical strain, myofascial strain of the trapezius and stable low back pain post-surgery. There is no record of recent diagnostic studies. The injured worker has been treated with surgery, physical therapy, TENS (transcutaneous electrical nerve stimulation) unit and medication management. In a progress note dated 2/11/2015, the treating physician reports persistent low back pain, right shoulder, and neck pain and is requesting physical therapy and an electric heating pad.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 3 times a week for 4 weeks, low back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-5, Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) present physical therapy PT guidelines, Patients should be formally assessed after a six-visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Medical records document a history of low back complaints. The date of injury was 11-30-2002. Past treatments have included physical therapy. The progress report dated 2/11/15 documented chronic low back pain status post lumbar spine surgery. No functional improvement with past physical therapy was documented. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. The request for 12 visits of PT physical therapy exceeds MTUS and ODG guidelines, and is not supported. Therefore, the request for physical therapy for the low back is not medically necessary.

**Electrical heating pad:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 - Lumbar & Thoracic (Acute & Chronic) Heat therapy.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses heat therapy. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints indicates that at-home local applications of heat or cold are as effective as those performed by therapists. Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) indicates that heat therapy is recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. One study compared the effectiveness of the [REDACTED] Back Plaster, the [REDACTED] Warne-Pflaster, and the [REDACTED] ThermaCare HeatWrap, and concluded that the ThermaCare HeatWrap is more effective than the other two. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and

disability in acute and sub-acute low-back pain. Heat therapy has been found to be helpful for pain reduction and return to normal function. The progress report dated 2/11/15 documented chronic low back pain status post lumbar spine surgery. The request for an electrical heating pad is supported by MTUS and ODG guidelines. Therefore, the request for an electrical heating pad is medically necessary.