

<b>Case Number:</b>	CM14-0065661		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	12/18/2013
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	04/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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: California  
 Certification(s)/Specialty: Family Practice

### 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 sustained a work related injury on December 18, 2013, injuring the lower back while carrying heavy construction material wood. The injured worker's conservative treatments were noted to have included physical therapy and oral and topical medications. A comprehensive physician's visit dated April 15, 2014, noted the injured worker with pain and discomfort involving the low back and left leg, with numbness and tingling in the left leg. Physical examination was noted to show decreased lumbosacral range of motion, positive straight leg raise test in the left leg, and decreased light touch sensation in the lateral aspect of the left leg. The current diagnoses were listed as lumbosacral sprain/strain injury, lumbosacral disc injury, clinical symptom of lumbosacral radiculopathy, and myofascial pain syndrome. The injured worker was noted to remain temporarily partially disabled with limitations of no pushing or pulling more than five pounds, and no back bending or twisting activities. The Physician requested authorization for infrared heat two times a week for four weeks for the lumbar spine, myofascial release two times a week for four weeks for the lumbar spine, and electro-acupuncture treatment two times a week for four weeks for the lumbar spine. On April 28, 2014, Utilization Review evaluated the request for infrared heat two times a week for four weeks for the lumbar spine, myofascial release two times a week for four weeks for the lumbar spine, and electro-acupuncture treatment two times a week for four weeks for the lumbar spine, citing the MTUS Acupuncture Medical Treatment Guidelines, and the MTUS Chronic Pain Medical Treatment Guidelines. The UR Physician noted the guidelines indicated that up to six initial acupuncture sessions may be tried initially to enable the provider to assess the efficacy of this

treatment modality. The UR Physician noted there had been no previous trial of acupuncture intervention, and that based on the clinical information submitted for review, and using the evidence-based, peer-reviewed guidelines, the request for infrared heat two times a week for four weeks for the lumbar spine, myofascial release two times a week for four weeks for the lumbar spine, and electro-acupuncture treatment two times a week for four weeks for the lumbar spine was not certified. The decision was subsequently appealed to Independent Medical Review.

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

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

#### **Infrared Heat 2 x Weeks x 4 Weeks, Lumbar Spine: Upheld**

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

**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 Complaints

**Decision rationale:** The MTUS Guidelines are silent on the use of cold/heat packs for the treatment of low back pain. However, the Official Disability Guidelines do comment on this treatment modality. These guidelines state the following: Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. In this case the patient's initial injury was in December, 2013. The Official Disability Guidelines recommend heat therapy as a modality for acute injuries. The duration of this patient's symptoms are well beyond the acute phase of the injury. Further, there is no justification provided in the request to indicate why an infrared device is necessary and why the patient is not able to self-apply a local heat pack to the affected area. Finally, the Official Disability Guidelines comment on continuous low level heat wrap. This request is for episodic infrared heat therapy. For these reasons, Infrared Heat 2 x Weeks x 4 Weeks, Lumbar Spine, is not medically necessary.

#### **Myofascial release 2 x week x 4 weeks, Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Manual Therapy & Manipulation as a treatment modality. These guidelines state the following: Manual therapy & manipulation - Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re- evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. In this case, the number of requested sessions exceeds the above cited MTUS guidelines. Further, it is unclear whether there will be monitoring for objective functional improvement to determine efficacy. Therefore, for these reasons, the use of Myofascial release 2 x week x 4 weeks to the Lumbar Spine is not considered medically necessary.

**Electra-Acupuncture Treatment 2 x Weeks x 4 Weeks, Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Page(s): 13.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Acupuncture as a treatment modality. These guidelines refer to Section 9792.24.1 of the California Code of Regulations, Title 8, under the Special Topics section. Section 9792.24.1 of the California Code of Regulations, Title 8, comments on the use of acupuncture. These guidelines state the following: That acupuncture is used as an option when pain medication is reduced or not tolerated. Further, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Based on the information in the medical records, there is no evidence that the requested service is being used as an adjunct to physical rehabilitation or surgical intervention. There is also no evidence in the medical records to indicate that the pain medications prescribed are being reduced or not tolerated. Therefore, the request is not considered medically necessary.