

<b>Case Number:</b>	CM15-0011582		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	05/28/2014
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Physical Medicine & Rehabilitation

### 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 53 year old female, who sustained an industrial injury on May 28, 2014. She has reported lower back pain with radiation to the left leg. The diagnoses have included lumbar spine stenosis, lumbosacral neuritis, lumbar spine disc displacement, and lumbosacral strain. Treatment to date has included medications, chiropractic, physical therapy, and imaging studies. A progress note dated December 4, 2014 indicates a chief complaint of continued lower back pain with radiation to the left leg. Physical examination was unrevealing as to the injured worker's symptoms. The treating physician requested follow up with pain specialist in one month, functional restoration three times each week for four weeks, and EMS infrared for the lumbar spine. On December 30, 2014 Utilization Review certified the request for follow up with pain specialist in one month. Utilization Review denied the request for functional restoration and EMS infrared citing the MTUS chronic pain medical treatment guidelines, ACOEM Guidelines, evidence based guidelines and ODG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional restoration three (3) times a week for four (4) weeks for the lumbar spine.:**  
 Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs (FRPs) Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration programs Page(s): 49.

**Decision rationale:** The 53 year old patient presents with pain in the lumbar spine, rated at 8/10, as per progress report dated 12/16/14. The request is for FUNCTIONAL RESTORATION THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LUMBAR SPINE. The RFA for the report is dated 12/16/14, and the patient's date of injury 05/28/14. In progress report dated 12/04/14, the patient complains of low back pain that radiates to left leg. Diagnoses, as per progress report dated 11/18/14, included lumbosacral radiculitis/neuritis, lumbar disc herniation, lumbar stenosis, and lumbosacral sprain/strain. MRI of the lumbar spine, dated 08/25/14 as per progress report dated 09/29/14, revealed severe facet arthropathy at L5-S1, left worse than right with high signal in the pedicle and superior articular facet adjacent to the L5-S1 joint. The patient is off work, as per progress report dated 12/01/14. The MTUS guidelines pg. 49 recommends functional restoration programs and indicate it may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. The guidelines further state that "Total treatment duration should generally not exceed 20 full-day sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 20 sessions requires a clear rationale for the specified extension and reasonable goals to be achieved." MTUS does not recommend more than "20 full-day sessions (or the equivalent in part-day sessions if required by part-time work transportation, childcare, or comorbidities)." In this case, the patient suffers from chronic and severe low back pain in spite of significant conservative care in form medications and physical therapy among other things. In progress report dated 12/16/14, the treater requests for functional restoration program "to help strengthen, rehabilitate and avoid reconditioning." The treater, however, does not discuss if the patient is eligible for other forms of treatment including a surgical intervention. It is not known if the patient is motivated to change and if all the negative predictors have been addressed. The reports lack documentation required to make a determination based on MTUS. The request IS NOT medically necessary.

**EMS Infrared for the lumbar area:** 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation chapter 'Lower Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Infrared therapy'

**Decision rationale:** The 53 year old patient presents with pain in the lumbar spine, rated at 8/10, as per progress report dated 12/16/14. The request is for EMS INFRARED FOR THE LUMBAR SPINE. The RFA for the report is dated 12/16/14, and the patient's date of injury 05/28/14. In progress report dated 12/04/14, the patient complains of low back pain that radiates to left leg. Diagnoses, as per progress report dated 11/18/14, included lumbosacral radiculitis/neuritis, lumbar disc herniation, lumbar stenosis, and lumbosacral sprain/strain. MRI of the lumbar spine, dated 08/25/14 as per progress report dated 09/29/14, revealed severe facet arthropathy at L5-S1, left worse than right with high signal in the pedicle and superior articular facet adjacent to the L5-S1 joint. The patient is off work, as per progress report dated 12/01/14. ODG guidelines, chapter 'Lower Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Infrared therapy', has the following to say "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise)." In this case, the patient suffers from chronic and severe low back pain. In progress report dated 12/01/14, the treater requests for EMS infrared for the lumbar spine but does not discuss the choice. ODG guidelines, however, do not support IR therapy over heat therapies. Hence, the request IS NOT medically necessary.