

<b>Case Number:</b>	CM13-0026373		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	06/10/1998
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	08/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### 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 Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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:

The injured worker is a 63 year old female who reported a pulling injury to her low back on 06/10/1998. On 07/11/2013 she reported having increased low back, left leg, groin and hip pain. Her lumbar flexion was measured at 16 inches from the floor with low back pain. Lumbar extension was 10/25 degrees with pain. The report stated that "other ranges of motion decreased approximately 50% with low back pain". The note further reported that Kemps test was positive bilaterally, but did not state what the "positive" findings revealed in terms of dermatomal pain indicating any level of nerve root compression. A straight leg raise was positive on the left at 75 degrees. In a 05/27/2013 chiropractic note, her diagnoses included lumbar intervertebral disc syndrome, lumbosacral sprain/strain and sacroiliac sprain/strain. The treatment plan was 30 chiropractic adjustments per year, EMS, traction and myofascial release. The only treatments noted were chiropractic. There was no documentation of any diagnostic studies. A request for authorization dated 07/11/2013 was included.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The request for Chiropractic is not medically necessary. CA MTUS recommends chiropractic 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 a passive treatment. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcome. Frequency recommendations are 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. There was not sufficient documentation of objective diagnostic information to be able to determine the physiological nature or etiology of this worker's pain. The most recent clinical note was dated 05/27/2013. There are insufficient recent data to support any therapeutic intervention. The request is for chiropractic with no mention of frequency, length of intended therapy or modalities to be employed. This worker had received chiropractic treatments in the past, but the length or frequency of past treatments or if any functional gains or pain relief was obtained is unknown. Therefore, this request for Chiropractic is not medically necessary.

**Electrical Stimulation Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

**Decision rationale:** The request for electrical stimulation unit is not medically necessary. CA MTUS recommends TENS units as being not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration in neuropathic pain, phantom limb pain and CRPS II, spasticity and multiple sclerosis. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Other ongoing pain treatment should also be documented during the trial period including medication usage, along with a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. There was not sufficient documentation of objective diagnostic information to be able to determine the physiological nature or etiology of this worker's pain. The most recent clinical note was dated 05/27/2013. There are insufficient recent data to support any therapeutic intervention. It is unknown if this worker had used any type of electrical stimulation unit previously and what, if any, functional improvement was

derived from its use. This worker does not have phantom limb pain, CRPSII spacticity or multiple sclerosis diagnoses. There was no specific treatment plan for the requested unit. The request does not specify if this is a rental or purchase. Therefore, this request for electrical stimulation unit is not medically necessary.

**Traction:** 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 - Lumbar & Thoracic, Traction.

**Decision rationale:** The request for traction is not medically necessary. ODG recommends that traction is not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain... The evidence suggests that any form of traction may not be effective... Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica. There was moderate evidence that auto-traction (patient controlled) was more effective than mechanical traction (motorized pulley) for global improvement in this population. (Clarke-Cochrane, 2005) Traction has not been shown to improve symptoms for patients with or without sciatica. (Kinkade, 2007) The evidence is moderate for home based patient controlled traction compared to placebo. There was not sufficient documentation of objective diagnostic information to be able to determine the physiological nature or etiology of this worker's pain. The most recent clinical note was dated 05/27/2013. There are insufficient recent data to support any therapeutic intervention. There was no information included regarding medications, past or present, physical therapy, exercise programs or any other documentation of conservative care, apart from chiropractic. The request is for traction without any specifics pertaining to the type of traction, amount of weight, body part(s) involved or time frames. Therefore this request for traction is not medically necessary.

**Myofascial Release:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** The request for myofascial release is not medically necessary. CA MTUS recommends that trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the

following criteria are met: Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; Symptoms have persisted for more than three months; Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; Radiculopathy is not present (by exam, imaging, or neuro-testing); and Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. There was not sufficient documentation of objective diagnostic information to be able to determine the physiological nature or etiology of this worker's pain. The most recent clinical note was dated 05/27/2013. There are insufficient recent data to support any therapeutic intervention. This worker does not have a diagnosis of myofascial pain syndrome. There was no documentation of a twitch response in this worker. There was no information included regarding medications, past or present, physical therapy, exercise programs or any other documentation of conservative care, apart from chiropractic. There were no diagnostic studies ruling out radiculopathy. No trigger points were identified upon examination. There were no data regarding what the injection(s) were to consist of nor where they were to be administered. Therefore, this request for myofascial release is not medically necessary.