

<b>Case Number:</b>	CM13-0063170		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	07/10/2013
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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 Internal Medicine and Emergency Medicine and is licensed to practice in Florida. 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:

This patient is a 50-year-old with a date of injury on 07/10/13. A handwritten progress report related to the request for services, dated 12/12/13, identified subjective complaints of wrist pain and right knee popping. The findings are difficult to read. The objective findings included tenderness to palpation of the right knee with crepitus, as well as right knee tenderness. The diagnoses included right knee patellofemoral chondromalacia; medial and lateral meniscus tears; and right wrist sprain. The treatment has included twelve (12) chiropractic sessions from September through October of 2013. There is no documentation of significant functional improvement related to the therapy. On a 08/23/13 progress report, it appears that ultrasound therapy was requested in conjunction with chiropractic sessions for the right knee. It is a handwritten note with incomplete legibility. A Utilization Review determination was rendered on 12/06/13 recommending non-certification of "8 additional chiropractic sessions; 1 right wrist ultrasound".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EIGHT (8) ADDITIONAL CHIROPRACTIC SESSIONS:** Upheld

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

**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, Manipulation

**Decision rationale:** The Chronic Pain Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. For the low back, they recommend a trial of six (6) visits over two (2) weeks. If there is objective evidence of functional improvement, a total of up to eighteen (18) visits over six to eight (6-8) weeks are recommended. Manual manipulation is not recommended for peripheral joints; specifically the ankle & foot, carpal tunnel, forearm, the wrist & hand, and the knee. In this case, the claimant has had twelve (12) chiropractic sessions, without specific documentation of functional improvement. An additional eight (8) sessions would exceed the guidelines. Also, the target of therapy was unclear, but appeared to be the knee. Therefore, there is no documented medical necessity for an additional eight (8) visits. The request is non-certified.

**ONE (1) RIGHT WRIST 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, Forearm, Wrist, & Hand (Acute & Chronic), and Rubin DA, Weissman BN, Appel M, Arnold E, Bencardino JT, Fries IB, Hayes CW, Hochman MG, Jacobson JA, Luchs JS, Math KR, Murphey MD, Newman JS, Scharf SC, Small KM, Expert Panel on Muscu

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

**Decision rationale:** The Chronic Pain Guidelines indicate that ultrasound therapy is not recommended. Despite sixty (60) years of using the modality, there is little evidence that shows that active therapeutic ultrasound is more effective than placebo. The original non-certification was based upon what appeared to be a request for a diagnostic ultrasound due to issues of legibility. The request actually appears to be for therapeutic ultrasound therapy. The medical record does not document the medical necessity for therapeutic ultrasound therapy. The request is non-certified.