

Case Number:	CM14-0152838		
Date Assigned:	09/23/2014	Date of Injury:	01/14/2002
Decision Date:	10/29/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/18/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 patient is a 60 year old male who sustained an industrial injury on 1/14/2002. The PR-2 dated 6/3/2014 documents the patient presents with complaint of moderate lumbar pain that radiates length of left leg daily, moderate daily bilateral knee pain and left foot neuropathic pain with lumbosacral flexion. Physical examination documents positive left Kemps, straight leg raise test and leg lowering, and decreased lumbar range of motion. He is currently diagnosed with degeneration lumbar/lumbosacral intervertebral disc, lumbosacral neuritis or radiculitis, and lumbar IVD syndrome. He is instructed to remain off-work. Treatment plan is for manual manipulation of affected articulations, flexion-distraction therapy, vertebral disc pump and laser therapy - all on as needed basis, ultrasound. A RFA dated 8/5/2014 requests spinal manipulation, ultrasound, flexion-distraction - approximately once every 15-20 days, and electrical stimulation and cold laser therapy - on as needed basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal manipulation (x every 15-20 days): 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 Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The California MTUS guidelines "recommend Manual therapy & manipulation 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. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." The patient has undergone an unknown number of chiropractic treatments. The medical records do not provide adequate documentation regarding his prior chiropractic care. It is unclear when he last attended chiropractic, the number of sessions completed, and there is lacking documentation supporting he obtained clinically significant functional improvement with prior treatment. Furthermore, the minimal findings on examination do not establish significant deficits exist as to support consideration for additional active care for this January 2002 industrial injury, more than 12+ years past. Furthermore, the request of treatment every 15-20 days appears more consistent with elective/maintenance care, which is not recommended. At this point, he should be versed in a home exercise program with focus on stretching, strengthening, and range of motion activities and application of self-applied modalities, such as ice/heat packs. The medical necessity for spinal manipulation every 15-20 days is not established. The request is not medically necessary.

Ultra sound (x every 15-20 days): 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
Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS guidelines state Ultrasound, therapeutic is not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. The medical records do not establish the requested spinal manipulation is appropriate and medically necessary, and so any adjunctive therapy is not indicated. Furthermore, the therapeutic ultrasound is not recommended, as there is little evidence to support the efficacy of this treatment. The request is not medically necessary.

Flexion-distraction (x every 15-20 days): Upheld

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): 49,300.

Decision rationale: According to the California MTUS ACOEM guidelines, traction is not recommended. Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. The medical records do not establish the requested spinal manipulation is appropriate and medically necessary, and so any adjunctive therapy is not indicated. Furthermore, traction is not recommended by the guidelines, as there is little evidence to support the efficacy of this treatment. The medical necessity of flexion-distraction is not established. The request is not medically necessary.

Elect stimulation as needed: 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 Electrical stimulators (E-stim), Page(s): 45.

Decision rationale: The medical records do not specify what type of form of electrical stimulation is being requested. Regardless, the guidelines do not generally support any of the various forms of electrical stimulators as the efficacy of this form of care has not been established. Certain forms of E-stim may be considered when certain criteria are met, which is not the case of this patient. Furthermore, the medical records do not establish the requested spinal manipulation is appropriate and medically necessary, and so any adjunctive therapy is also not indicated. The request is not medically necessary.

Cold laser therapy as needed: 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 Low-Level Laser Therapy (LLLT), Page(s): 57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Low level laser therapy (LLLT)

Decision rationale: According to the California MTUS and Official Disability Guidelines, cold laser or LLLT, is not recommended. There has been interest in using low-level lasers as a conservative alternative to treat pain. Low-level lasers, also known as "cold lasers" and non-thermal lasers, refer to the use of red-beam or near-infrared lasers with a wavelength between 600 and 1000 nm and wattage from 5-500 milliwatts. Studies have concluded that there are insufficient data to draw firm conclusions about the effects of LLLT for low-back pain compared to other treatments, different lengths of treatment, different wavelengths and different dosages. This form of treatment is not recommended as efficacy is not established. Furthermore, the medical records do not establish the requested spinal manipulation is appropriate and medically

necessary, and so any adjunctive therapy is also not indicated. The request is not medically necessary.