

<b>Case Number:</b>	CM14-0048106		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/04/1985
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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 Occupational 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:

This is a 73-year-old male patient with a 1/14/1985 date of injury. He injured himself, while working as a firefighter and fell from 12 feet height. A progress report dated on 4/1/14 indicated that three weeks ago the patient felt severe left lumbar pain, which radiated down to the left leg into the big toe. He stated that the pain was associated with tingling in the left foot as well as a left foot drop. Physical exam revealed positive straight leg rising on the left side, at 55 degrees. There was 2+ spasm and tenderness in the bilateral lumbosacral paraspinal region. His range of motion was not associated with the pain. He was diagnosed with Chronic lumbosacral musculoligamentous sprain and Left foot drop, most likely to L5-S1 radiculopathy. Treatment to date: medication management and chiropractic therapy, which was helpful for back pain and had little effect for foot drop and tingling. There is documentation of a previous 3/21/14 adverse determination, based on the fact that there was no evidence of significant deficit on examination as well as recent exacerbation, additional skilled intervention was not certified. Ultrasound was not certified, because guidelines did not support, due to limited evidence of effectiveness. Myofascial release was not certified, based on the fact that there was no indication that the patient participated in active exercise to support the request for massage therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(6) Sessions of Non-Surgical Spinal Decompression:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines (Manual therapy and manipulation) Page(s): 58.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that with evidence of objective functional improvement with previous treatment and remaining functional deficits, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. The patient presented with lower back pain radiating to the left leg. It was noted that the patient had pain relief following chiropractic treatment. However, there was no objective documentation to assess pain relief. In addition, it was not clear how many sessions of chiropractic treatment the patient had received, although over 30 dates of service were listed on a July 7, 2014 report. The guidelines supported 18 sessions of treatment. Therefore, the request for (6) Sessions of Non-Surgical Spinal Decompression is not medically necessary.

**Ultrasound:** Upheld

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

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

**Decision rationale:** CA MTUS states that therapeutic ultrasound is not recommended, with little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating pain or a range of musculoskeletal injuries or for promoting soft tissue healing. The patient presented with the pain in his lower back pain radiating to the left leg into the big toe. There was noted that the patient had pain improvement with the chiropractic treatment. However, CA MTUS does not support ultrasound treatment, because of little evidence of effectiveness. Therefore, the request for Ultrasound is not medically necessary.

**Myofascial Release:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** CA MTUS states that massage therapy should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. There was noted that the patient had chiropractic treatment. However, there was no documentation supporting of patient attending any exercise program. In addition, over 30 dates

of service were listed on a July 7, 2014 report including myofascial release. Therefore, the request for Myofascial Release is not medically necessary.