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| <b>Case Number:</b>   | CM14-0089605 |                              |            |
| <b>Date Assigned:</b> | 07/23/2014   | <b>Date of Injury:</b>       | 09/08/2011 |
| <b>Decision Date:</b> | 09/19/2014   | <b>UR Denial Date:</b>       | 05/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/12/2014 |

### 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 & 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 68-year-old male who has submitted a claim for low back pain and right knee pain associated with an industrial injury date of 9/8/2011. There was no progress report submitted for review. Per utilization review, the injured worker complained of low back pain and right knee pain. Physical examination findings showed tenderness and restricted motion of the lumbar spine. Straight leg raise test was positive at the right. There was tenderness over the right knee. Utilization review from 6/7/2014 denied the retrospective request for 18 spinal manipulation 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 because there was no documentation of functional improvement from previous sessions; denied retrospective 18 ultrasound 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 because the guideline did not recommend ultrasound as management of acute knee and back pain because of no proven efficacy; and denied retrospective 18 interferential muscle stimulation 3x/wk for 5-6 weeks between 9/23/2011 and 11/4/2011 because evidence-based guidelines did not support to use of interferential stimulation as management of low back pain or knee pain; and denied retrospective 18 intersegmental traction 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 because it was not proven effective for lasting relief in treating low back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for 18 spinal manipulation 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 298-300; 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 9792.20 - 9792.26, Manipulation Therapy Page(s): 58-59.

**Decision rationale:** As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, there was no progress report available for review. There was no documented rationale for this request. The medical necessity was not established due to insufficient information. Therefore, the retrospective request for 18 spinal manipulations, 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 was not medically necessary.

**Retrospective 18 ultrasound 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011: 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) Knee and Leg chapters, ESWT.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. The ODG states, that extracorporeal shock wave therapy (ESWT) is under study for patellar tendinopathy and for long-bone hypertrophic nonunion. In this case, there was no progress report available for review. There was no documented rationale for this request. The medical necessity was not established due to insufficient information. Therefore, the retrospective request for 18 ultrasounds, 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 was not medically necessary.

**Retrospective 18 interferential muscle stimulation 3x/wk for 5-6 weeks between 9/23/2011 and 11/4/2011.: 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 Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated

intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, there was no progress report available for review. There was no documented rationale for this request. The medical necessity was not established due to insufficient information. Therefore, the retrospective request for 18 interferential muscle stimulation 3x/wk for 5-6 weeks between 9/23/2011 and 11/4/2011 was not medically necessary.

**Retrospective 18 intersegmental traction 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

**Decision rationale:** As stated on pages 298-301 of ACOEM Low Back Complaints referenced by CA MTUS, traction is not recommended since it has not been proven effective for lasting relief in treating low back pain. In this case, there was no progress report available for review. There was no documented rationale for this request. The medical necessity was not established due to insufficient information. Therefore, the retrospective request for 18 intersegmental tractions 3x/wk for 5-6 wks between 9/23/2011 and 11/4/2011 was not medically necessary.