

<b>Case Number:</b>	CM15-0034961		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	12/12/2014
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 43 year old female, who sustained an industrial injury on 12/12/2014. The diagnoses have included right ankle sprain/strain, right foot contusion, plantar fasciitis, heel spur, right knee sprain/strain, lumbar spine musculoligamentous sprain/strain and right sacroiliac (SI) joint sprain. Treatment to date has included a surgical shoe and medication. According to the doctor's first report of occupational injury or illness dated 1/16/2015, the injured worker complained of right foot and ankle pain, right knee pain and low back pain. Exam of the lumbar spine revealed tenderness to palpation over the paravertebral musculature, right side greater than left with muscle spasm and tenderness to palpation over the sacroiliac (SI) joint. Exam of the right knee revealed tenderness to palpation over the medial and lateral joint lines. Exam of the right foot/ankle revealed evidence of moderate hypertonicity. Authorization was requested for chiropractic treatment, an interferential unit, orthotics and Fexmid 7.5mg. On 1/26/2015 Utilization Review (UR) modified a request for twelve chiropractic sessions to six chiropractic sessions. UR non-certified a request for one interferential stimulation unit. The American College of Occupational and Environmental Medicine (ACOEM) Guidelines and Official Disability Guidelines (ODG) were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 chiropractic sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability Guidelines Chiropractic Guidelines.

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

**Decision rationale:** According to MTUS guidelines, Manual therapy & manipulation: Recommended 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 manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The patient developed chronic back pain and musculoskeletal disorders. She is a candidate for treatment with acupuncture. However, the frequency of the treatment should be reduced from 12 to 6 or less sessions. More sessions will be considered when functional and objective improvement are documented. Therefore, the request for 12 Chiropractic visits is not medically necessary.

**1 interferential stimulation unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** According to MTUS guidelines, Interferential Current Stimulation (ICS). Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or- Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). There is no clear evidence that the

patient did not respond to conservative therapies, or have pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. There is no evidence of functional deficit that required neuro stimulator therapy. There is no documentation of the outcome of previous physical therapy and TENS. Therefore, the request for 1 interferential stimulation unit is not medically necessary.