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| Case Number: | CM15-0014207 | | |
| Date Assigned: | 02/03/2015 | Date of Injury: | 02/08/2014 |
| Decision Date: | 03/25/2015 | UR Denial Date: | 12/23/2014 |
| Priority: | Standard | Application Received: | 01/26/2015 |

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 62-year-old female, with a reported date of injury of 02/08/2014. The diagnoses include lumbar spine sprain/strain and left knee medial and lateral meniscus tear. Treatments have included an MRI of the left knee on 06/17/2014, chiropractic treatment, an electromyography and nerve conduction study of the left lower extremity on 10/31/2014, an MRI of the lumbar spine on 08/28/2014, an MRI of the left sciatic nerve on 08/28/2014, and an MRI of the lumbosacral plexus on 08/28/2014. The progress report dated 11/14/2014 indicates that the injured worker complained of low back pain, with radiation to the left lower extremity, left knee pain, radiating down to the ankle, left shoulder pain, bilateral hip pain, and bilateral ankle pain. The objective findings include normal lumbar curvature, tenderness to palpation over the left para lumbar musculature with spasm, full active range of motion, negative supine and seated straight leg raise, tenderness to palpation over the medial joint line of the left knee, and McMurray's test positive for a medial meniscus tear. The treating physician requested continued chiropractic treatment for the lumbar spine and left knee, and the purchase of an interferential (IF) 4 unit at home for the pain symptoms. By 11/14/14, the claimant had received 22 sessions of physical therapy and 16 sessions of chiropractic therapy. On 12/23/2014, Utilization Review (UR) denied the request for the purchase of an interferential (IF) 4 unit, and chiropractic treatment once a week for four weeks for the low back and left knee. The UR physician noted that it was not clear that the criteria for the use of an IF 4 unit had been met, there was no documentation that pain was ineffectively controlled with medications due to side effects, no documentation of a history of substance abuse, and that the response after completion of

chiropractic treatment should be assessed before recommending additional chiropractic treatment. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of IF 4 unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF unit Page(s): 118.

Decision rationale: According to the guidelines, an IF unit is 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. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. In this case, the request is for a home purchase, implying long-term use. The frequency and duration of using the unit was not outlined and there are no defined guidelines for its use in the literature. The claimant had used an IF unit in combination with therapy, medications and chiropractor. Direct benefit response cannot be determined. As a result, the request for an IF unit purchase is not medically necessary.

Chiropractic once a week for four weeks for the low back and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Medicine Page(s): 58.

Decision rationale: According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. The request for 4 more sessions exceeds the amount of the guidelines. In addition, the claimant had completed numerous physical therapy sessions. There is no indication that additional benefit cannot be obtained from home exercises. As a result additional chiropractor therapy is not necessary.