

Case Number:	CM13-0033853		
Date Assigned:	12/06/2013	Date of Injury:	05/04/2009
Decision Date:	05/14/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	10/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Arizona. 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 physician 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 58-year-old female who sustained an injury on 5/5/09. Her diagnoses include cervical and thoracic disc bulges, failed right shoulder surgery, and left shoulder strain. The patient underwent electrodiagnostic studies that revealed a mild left C6 radiculopathy. An MRI of the cervical spine revealed moderate narrowing and disc deck attenuation at C5-C6. There was 3 mm of posterior and central disc encroachment. The provider note on 10/31/13, mentions the patient still having neck pain shooting down the left upper extremity. There is mention of decreased sensation to touch and tingling in the left upper extremity including the thumb, the long finger, and the tip of the little finger. The patient uses a cane to ambulate. The patient's list of medications include Lidoderm, Flexeril, Norco, and Lyrica. The patient has had extracorporeal shockwave treatment to her cervical spine, both shoulders and into her upper back in the past. The results of these treatments are unknown. A request is made for six (6) cervical shockwave treatments, also for a pneumatic traction unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL SHOCKWAVE TREATMENT 1X6 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Extracorporeal shock wave therapy

Decision rationale: There is no specific mention of cervical shockwave treatment in the MTUS or the Official Disability Guidelines (ODG). There is mention of using shockwave treatment for calcific tendinitis of the shoulder, chronic epicondylitis, plantar fasciitis, and patella tendinitis. In none of these conditions is there strong evidence for the efficacy of shockwave treatment. The Official Disability Guidelines indicate that shockwave therapy is only effective in the shoulder for calcific tendinitis. The use of cervical shockwave therapy is purely experimental and there is no evidence-based criteria to support it. Therefore, the medical necessity for cervical shockwave treatment is not established.

SANDERS PNEUMATIC TRACTION WITH US CONDUCTIVE GEL-CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181.

Decision rationale: The MTUS/ACOEM Guidelines do not recommend traction as one of the physical treatment methods for neck and upper back complaints. There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive modalities such as traction in the treatment of neck and upper back problems. The focus should be on functional restoration and returning the patient to activities of normal daily living. Therefore, the medical necessity for a Sanders pneumatic traction with ultrasound conductive gel has not been established.