

Case Number:	CM13-0040511		
Date Assigned:	12/20/2013	Date of Injury:	04/09/2004
Decision Date:	05/06/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/29/2013

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 Family Practice, 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 65 year old male claimant sustained a work-related injury on 4/9/04, resulting in chronic neck, hip, shoulder and back pain. She was diagnosed with cervical spine disc bulge, bilateral shoulder strain, bilateral hip strain, multi-level disc desiccation, and probable lumbar disc rupture. She had used oral analgesics for pain as well as undergone acupuncture in September 2012 and extracorporeal shock wave therapy in December 2012. An exam note on 6/13/13 indicated continued spinal and upper extremity pain. A progress note on 9/10/13 indicated that the claimant has continued pain in most of the prior injured regions. The examination did not indicate any neurological abnormalities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXTRACORPOREAL SHOCK WAVE THERAPY, ONCE A WEEK FOR 6 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation InterQual criteria

Decision rationale: The MTUS, ACOEM, Official Disability Guidelines do not comment on shock wave therapy. During Shockwave therapy (ESWT), a high-intensity sound wave interacts with the tissues of the body. This leads to beneficial effects such as neovascularization in growth, reversal of chronic inflammation, stimulation of collagen, and dissolution of calcium build-up. According to the InterQual guidelines, ESWT is an alternative to surgery for patients with chronic plantar fasciitis for 6 months who failed conservative treatment, chronic epicondylitis for 6 months who failed conservative treatments, and/or chronic rotator cuff tendonitis for 6 months that failed conservative treatment. It is experimental for Achilles tendinopathy, delayed unions, erectile dysfunction, low back pain, non-unions, osteonecrosis of the femoral head, patellar tendinopathy, Peyronie's disease, stress fractures, and wound healing. The claimant had already received shock wave therapy a year ago with no documented improvement. Based on the criteria above, shock wave therapy is not medically necessary for spinal and joint pain. The request is noncertified.

CHIROPRACTIC TREATMENT ONCE A WEEK FOR SIX WEEKS FOR THE CERVICAL/THORACIC/LUMBAR SPINE AND RIGHT UPPER EXTREMITY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY Page(s): 59.

Decision rationale: According to the MTUS guidelines, manual therapy & manipulation is recommended for chronic pain if caused by musculoskeletal conditions. It is recommended as an option for the low back with a trial of 6 visits over 2 weeks; with evidence of functional improvement, a total of up to 18 visits over 6-8 weeks may be certified. In this case, the examination did not describe any objective findings that would necessitate manual therapy. The response to pain medications was not noted. Anticipated response to treatment was not mentioned. Although chiropractic treatment is an option, it is not medically necessary in this case based on unsubstantiated information in the progress notes. The request is noncertified.

ACUPUNCTURE ONCE A WEEK FOR SIX WEEKS FOR THE CERVICAL/THORACIC/LUMBAR SPINE AND RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may also be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery, to reduce pain, to reduce inflammation, to increase blood flow, to increase range of motion, to decrease the side effects of medication-induced nausea, to promote relaxation in an anxious patient, and to reduce muscle spasm. The time to produce functional improvement is 3-6 treatments. Treatment may be

extended if functional improvement is documented. In this case, the claimant had already completed several acupuncture treatments. The response to prior treatments is not known. The additional request also exceeds the amount of treatments recommended. The request is noncertified.