

<b>Case Number:</b>	CM13-0042644		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 Physical Medicine and 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:

This male sustained an injury on 6/17/13 while employed by [REDACTED]. Requests under consideration include ONE CHIRO VISIT RETRO TO 8/19/13, ONE PHYSICAL THERAPY VISITS RETRO TO 8/19/13, and THREE EXTRACORPOREAL SHOCKWAVE THERAPY VISITS FOR BILATERALLY UPPER EXTREMITIES RETRO TO 8/19/13. Per report dated 8/19/13 from the chiropractic provider, an MRI of the lumbar spine on 7/16/13 showed multi-lobulated and multi-cystic left renal pelvis measuring 6.5 cm; MRI of the left shoulder dated 7/22/13 showed AC osteoarthritis and supraspinatus tendinitis. The patient report moderate to severe intermittent bilateral hands/wrists and left shoulder pain with low back pain and weakness and cramping in right leg. Cervical spine exam noted tenderness over paravertebral muscles and upper trapezius bilaterally with spasm over left paravertebral muscles; tenderness and hypomobility over the vertebral regions from C2-7; shoulder depression positive on left; range of cervical spine with limited range in all planes; tenderness of supraspinatus and infraspinatus muscles of left and AC joint; positive left Hawkins with decreased range in all planes of left and right shoulder; tenderness over wrists and carpal tunnel; positive bilateral Tinel's and Finkelstein's with painful range of bilateral wrists; dysesthesia at C7-8 and L5-S1; tenderness and spasm from T2-T10; hypomobility L1-S1 with tenderness at SI joints and sciatic notches; tenderness in all digits 1-5 including metatarsals. Diagnoses include cervical, thoracic, and lumbar sprain/strain; bilateral shoulders and wrists sprain/strain; and bilateral ankle pain. Treatment recommendation included MRIs of cervical and thoracic spine; electrodiagnostics, lumbar spine traction, acupuncture, physiotherapy, and chiropractic treatments 1x/month consult podiatrist. The patient remained temporarily totally disabled. Treatment requests above were non-certified on 10/16/13 citing guidelines criteria and lack of medical necessity.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **ONE CHIRO VISIT RETRO TO 8/19/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The Chronic Pain Medical Treatment Guidelines, Manual Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Low Back Complaints Page(s): 298-300.

**Decision rationale:** MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. The patient has received significant conservative treatments of physical therapy including chiropractic treatments; however, has no report of improvement with unchanged chronic pain complaints. Clinical exam remains unchanged and without deficits. Submitted reports have not demonstrated any flare-up or new red-flag findings to support further treatment. Guidelines states 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. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with co morbidities. Such care should be re-evaluated and documented and treatment beyond 4-6 visits should be documented with objective improvement in function. However, this has not been shown in this case as the patient has remained TTD. The ONE CHIRO VISIT RETRO TO 8/19/13 is not medically necessary and appropriate.

### **ONE PHYSICAL THERAPY VISITS RETRO TO 8/19/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Physical Therapy, Page(s): 98-99.

**Decision rationale:** Present complaints are continued chronic pain with unchanged clinical findings. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. Submitted reports have not demonstrated any indication to support for additional therapy and the patient should continue the previously instructed HEP. The ONE PHYSICAL THERAPY VISITS RETRO TO 8/19/13 is not medically necessary and appropriate.

**THREE EXTRACORPOREAL SHOCKWAVE THERAPY VISITS FOR  
BILATERALLY UPPER EXTREMITIES RETRO TO 8/19/13: 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:** Decision based on MTUS ACOEM Page(s): 203, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Extracorporeal shock wave therapy (ESWT) Shoulder, Page(s).

**Decision rationale:** The Official Disability Guidelines recommend extracorporeal shockwave therapy to the shoulder for calcific tendinitis and do not recommend for elbow strain/sprain or epicondylitis as long-term effectiveness has not been evident. Diagnosis include shoulder impingement and shoulder and elbow strain/sprain. Submitted reports have not adequately demonstrated any diagnosis or clinical findings of the upper extremities to support for the ECSW treatment. The THREE EXTRACORPOREAL SHOCKWAVE THERAPY VISITS FOR BILATERALLY UPPER EXTREMITIES RETRO TO 8/19/13 are not medically necessary and appropriate.