

Case Number:	CM13-0055023		
Date Assigned:	12/30/2013	Date of Injury:	06/13/2005
Decision Date:	03/21/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/20/2013

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 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 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 64-year-old female who was injured on 06/13/2005 while working as a court reporter. The patient reportedly developed orthopedic conditions as a result of the stress and strain of her work, which entailed lifting equipment weighing 30 pounds. Prior treatment history has included extensive conservative care including physical therapy, acupuncture, injections (cervical and lumbar), five (5) extracorporeal shockwave therapy sessions (for diagnosis of lumbar spine pain) and prescription medications. Medications include hydrocodone, Carisoprodol, and meprobamate. An MRI of the cervical spine performed on 06/22/2013 revealed C3-4, with mild narrowing and a 3-4 mm posterior central to right posterior disc extrusion. An electromyography/nerve conduction velocity (EMG/NCV), dated 07/28/2005 revealed that both the upper and lower limbs were normal. PR-2 (progress report) dated 10/03/2013 documented that the patient had complaints of pain in the right knee, right ankle, neck, upper back, lower back, bilateral shoulders and bilateral wrists. The physical exam was limited to light touch sensation stating: "right lateral shoulder intact, right index tip intact, right dorsal thumb web intact, right small tip intact". PR-2 dated 08/15/2013 documented pain at 8/10 with decreased sensation at the right C5. A pain management consultation, dated 02/28/2013 revealed that the patient complained of pain in her neck, which radiates down both her shoulders (rated 8/10); a physical examination reported 5/5 strength bilaterally in the upper extremities, with decreased sensation in the bilateral C5 dermatomes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy once a week for six (6) weeks for the cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary, last updated 10/14/2013.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CMS National Coverage Policy, Coverage Indications, Limitations, and/or Medical Necessity, <http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=32729&ContrId=249&ver=17&ContrVer=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=>

Decision rationale: According to the guidelines, the medical literature does not clearly establish the clinical efficacy of the procedure and therefore the service is considered not medically necessary. Additionally, there is no evidence supporting the use of shockwave therapy in several standard textbooks for the management of chronic pain in the cervical spine.

Chiropractic treatment twice a week for six (6) weeks for the cervical spine, thoracic spine, and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Physical Medicine and Rehabilitation, 3rd Edition, 2007, Chapter 20: Manipulation, Traction and Massage, pages 437-458.

Decision rationale: The Chronic Pain Guidelines allow for chiropractic treatment (manual therapy) for musculoskeletal conditions. The overall intended goal or effect of treatment is to achieve positive overall gains in functional improvement. The records presented only report a decrease in sensation in the upper extremities, there is no mention of the requesting providers intended goal for this type of treatment request. Further, the guidelines recommend therapeutic care based on a trial of six (6) visits over two (2) weeks and with evidence of objective functional improvement. A total of up to eighteen (18) visits over six to eight (6-8) weeks may be an option. The requested number of visits also exceeds the recommended number of visits.