MAXIMUS Federal Services

Case Number:	CM14-0004702		
Date Assigned:	01/24/2014	Date of Injury:	07/24/2012
Decision Date:	06/24/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/13/2014

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 Pain Management, has a subspecialty in Interventional Spine 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:

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 51 year old female with date of injury of 07/24/2012. According to the report, the patient complains of right-sided headaches, neck pain, shoulder pain, mid and low back pain, and lower extremity pain. She rates her neck, bilateral knee, lower leg, ankle and head pain 6-9/10. She also reports bilateral shoulder and elbow pain at 6-8/10 in severity. The patient reports numbness and tingling in the bilateral hands/wrist and back and rates it a 4-6/10. The exam shows tenderness and spams over the paravertebral musculature bilaterally as well as the upper trapezius musculature on the right. Tenderness is present over the vertebral regions from C2 through C7. Cervical compression test is positive on the right. Hawkins orthopedic test is positive bilaterally. Wrist Extensor (C6) and Wrist Flexor (C7) motor testing is 4/4 bilaterally. Tenderness is present over the vertebral regions from T2 through T8. Kemp's test is positive. Straight Leg Raising Test (supine) was with back pain: Right: 50 and Left: 50. The utilization review denied the request on 12/10/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Physiotherapy/chiro to the cervical/thoracic/lumbar/bilateral shoulder/bilateral elbow/bilateral wrist/hand/bilateral hip/thigh/bilateral knee/foot/ankle three times per week for four weeks.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment for Workers' Compensation (TWC).

Decision rationale: This patient presents with chronic pain in multiple areas. The treating physician is requesting a retrospective request for 12 physiotherapy/chiropractic treatment. The MTUS Guidelines page 98 and 99 recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. Furthermore, MTUS page 58 and 59 on chiropractic treatments recommends a trial of 6 visits over 2 weeks and with functional improvement up to 18 visits over 6-8 weeks. The report dated 03/05/2013 shows that the patient is continuing with an unknown number of physical therapy visits. The succeeding reports do not show any functional improvement or decrease in pain levels. Moreover, the treater's request of 12 visits exceeds MTUS guidelines for both physical therapy and chiropractic treatments. The request is not medically necessary and appropriate.

Retro: Extacorporeal Shockwave therapy to the cervical/thoracic/lumbar/bilateral shoulder/bilateral elbow/bilateral wrist/hand/bilateral hip/thigh/bilateral knee/foot/ankle three times per week for four weeks.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment for Workers' Compensation (TWC).

Decision rationale: This patient presents with chronic pain in multiple areas. The treating physician is requesting a retrospective for 12 Extracorporeal shockwave therapy to the cervical/ thoracic/ lumbar/ bilateral shoulder/ bilateral elbow/ bilateral wrist/hands/bilateral hip/thigh/bilateral knee/ foot/ankle. Per ODG guidelines, Extracorporeal shockwave therapy is indicated for the calcific tendinitis of the shoulders, tendinitis of elbow and plantar fasciitis but not recommended for any spinal or other conditions. In this case, the treating physician has provided numerous ECST to multiple body parts without appropriate indications. Twelve sessions of treatments without checking for the patient's response is also not supported by guidelines. The request is not medically necessary and appropriate.