

Case Number:	CM14-0010442		
Date Assigned:	02/21/2014	Date of Injury:	07/24/2012
Decision Date:	06/27/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/23/2014

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 is licensed to practice in Illinois. 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 injured worker is a 51-year-old female who reported an injury on 07/24/2012. The mechanism of injury involved a fall. Current diagnoses include cephalgia, cervical sprain, cervical facet induced versus discogenic pain, thoracic sprain, thoracic myofasciitis, lumbar sprain, lumbar radiculitis, status post lumbar surgery in 2000, shoulder sprain, shoulder tenosynovitis, bilateral shoulder rotator cuff tear, elbow/forearm sprain, epicondylitis, wrist sprain, de Quervain's tenosynovitis of the thumb, carpal tunnel syndrome, knee and lower leg sprain, knee internal derangement, right knee lateral meniscus tear, ankle/foot sprain, ankle tenosynovitis, hallux valgus deformity, pes planus, insomnia, and anxiety/depression. The injured worker was evaluated on 06/24/2013. The injured worker reported persistent pain over multiple areas of the body. Physical examination revealed tenderness to palpation of the cervical spine, positive compression testing, positive shoulder depression testing, limited cervical range of motion, tenderness and spasm over the supraspinatus musculature, positive Hawkin's testing, limited shoulder range of motion, tenderness over the lateral epicondyle bilaterally, positive Cozen's testing, tenderness over the volar and dorsal crease of the wrist bilaterally, tenderness over the carpal tunnel bilaterally, positive Tinel's and Phalen's testing, positive Finkelstein's testing, limited wrist range of motion bilaterally, decreased grip strength tenderness to palpation of the thoracic spine, positive Kempt's testing, limited thoracic and lumbar range of motion, positive straight leg raising, tenderness over the medial and lateral joint line bilaterally, limited knee range of motion bilaterally, tenderness to palpation over this sinus tarsi and tibialis posterior tendons bilaterally, and positive pes planus bilaterally with hyperpronation. Treatment recommendations at that time included physiotherapy treatment with chiropractic therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE PHYSIOTHERAPY/CHIRO 3 TIMES A WEEK FOR 4 WEEKS (12 SESSIONS): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: The California MTUS Guidelines state manual therapy and manipulation are recommended if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. The current request for 12 sessions of chiropractic therapy exceeds guideline recommendations. There is also no specific body part listed in the current request. Therefore, the Retrospective Request for Physiotherapy/Chiro 3 Times A Week For 4 Weeks (12 Sessions) is not medically necessary.

EXTRACORPOREAL SHOCKWAVE THERAPY TO THE CERVICAL/THORACIC/LUMBAR/BILATERAL SHOULDER/BILATERAL ELBOW/BILATERAL WRIST/HAND/BILATERAL HIP/THIGH/ BILATERAL KNEE/FOOT/ANKLE 3 TIMES A WEEK FOR 4 WEEKS (12 SESSIONS): Upheld

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

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

Decision rationale: The California MTUS/ACOEM Practice Guidelines state there is limited evidence regarding extracorporeal shockwave therapy in treating plantar fasciitis to reduce pain and improve function. Physical modalities have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Physical modalities have no proven efficacy in treating acute low back symptoms. There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities for treatment of acute neck and upper back complaints. There is medium quality evidence to support extracorporeal shockwave therapy for calcifying tendinitis of the shoulder. As per the documentation submitted, the injured worker does not maintain a diagnosis of plantar fasciitis or calcifying tendinitis of the shoulder. There are no guideline recommendations for treating acute cervical, thoracic, or lumbar spine complaints with extracorporeal shockwave therapy. There are also no guideline recommendations for treating acute hand, wrist, hip, or thigh complaints with extracorporeal shockwave therapy. Based on the clinical information received and the California MTUS/ACOEM Practice Guidelines the request is non-certified. The request for Extracorporeal Shockwave Therapy To The Cervical/Thoracic/Lumbar/Bilateral Shoulder/Bilateral Elbow/Bilateral Wrist/Hand/Bilateral Hip/Thigh/ Bilateral Knee/Foot/Ankle 3 Times A Week For 4 Weeks (12 Sessions) is not medically necessary.

