

Case Number:	CM14-0174373		
Date Assigned:	10/27/2014	Date of Injury:	06/13/2005
Decision Date:	12/11/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/21/2014

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 & 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:

Patient is a 64-year-old female who has submitted a claim for neck sprain/strain, bilateral C5 radiculopathy, lumbar sprain/strain, rotator cuff sprain, and bilateral wrist sprain/strain associated with an industrial injury date of 6/13/2005. Medical records from 2014 were reviewed. Patient complained of pain at the neck, upper back, lumbar back, both shoulders, and both wrists. Patient reported that previous chiropractic treatment and shockwave therapy afforded her pain relief with increased mobility and functionality. Patient was interested to attend repeat sessions. Physical examination showed tenderness at the cervical spine, thoracic spine, and lumbar spine. Range of motion was restricted and painful. Sensory was intact. Treatment to date has included extracorporeal shockwave therapy, cervical epidural steroid injection, chiropractic care, acupuncture, and medications. Utilization review from 9/30/2014 denied the request for shock wave therapy one time a week for 6 weeks cervical, lumbar and thoracic spine because of no evidence of any significant change in the patient's functional status despite previous treatment; denied chiropractic visits one time a week for 6 weeks cervical, lumbar and thoracic spine because of limited information regarding the number of completed sessions and objective gains derived from prior chiropractic care; and denied acupuncture sessions one time a week for 6 weeks old cervical, lumbar and thoracic spine because of limited data concerning clinical gains from completed visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy 1 time a week for 6 weeks cervical, lumbar and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Shockwave Therapy

Decision rationale: According to page 203 of the ACOEM Practice Guidelines referenced by CA MTUS, physical modalities, such as ultrasound treatment, etc. are not supported by high-quality medical studies. ODG states that shockwave therapy is not recommended. The available evidence does not support the effectiveness of extracorporeal shockwave therapy (ESWT) for treating LBP. The CA MTUS and ODG are silent regarding ESWT to the cervical spine. A search for scientific literature failed to yield high-quality studies, which addressed the efficacy and safety of application of ESWT to the cervical spine. In the absence of such evidence, the clinical use of this treatment is not justified and should be discouraged. In this case, patient completed a course of ESWT in the past leading to pain relief, increased mobility and functionality. However, there was no data concerning objective functional gains derived from treatment. Moreover, records reviewed failed to establish compelling circumstances, identifying why ESWT for the cervical and lumbar areas be required despite adverse evidence. There was no compelling rationale concerning the need for variance from the guidelines. Therefore, the request for Shockwave therapy 1 time a week for 6 weeks cervical, lumbar and thoracic spine was not medically necessary.

Chiropractic visits one time a week for 6 weeks cervical, lumbar and thoracic spine:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Therapy Page(s): 58-59.

Decision rationale: As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, 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. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient completed a course of chiropractic care in the past leading to pain relief, increased mobility and functionality. However, there was no information concerning total number of visits attended, as well as objective functional gains derived from treatment. The medical necessity cannot be established due to insufficient information. Therefore, the request for Chiropractic visits one time a week for 6 weeks cervical, lumbar and thoracic spine was not medically necessary.

Acupuncture sessions one time a week for 6 weeks to cervical, lumbar and thoracic spine:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient completed a course of acupuncture in the past leading to pain relief, increased mobility and functionality. However, there was no information concerning total number of visits attended, as well as objective functional gains derived from treatment. There was also no evidence of decreased medication-usage associated with acupuncture. Therefore, the request for acupuncture sessions one time a week for 6 weeks to cervical, lumbar and thoracic spine was not medically necessary.