

Case Number:	CM14-0023725		
Date Assigned:	05/12/2014	Date of Injury:	01/21/2009
Decision Date:	07/10/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/24/2014

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, 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 patient is a 58-year-old female with a date of injury of 01/21/2009. The listed diagnoses per [REDACTED] are: 1. Cervical spine myofascitis. 2. Cervical spine sprain/strain. 3. Cervical spine disk protrusions. 4. Lumbar spine myofascitis. 5. Lumbar spine sprain/strain. 6. Lumbar spine disk protrusions. 7. Lumbar spine radiculopathy. 8. Right shoulder status post arthroscopy on 04/19/2013. 9. Left knee sprain/strain. 10. Left knee internal derangement. 11. Left ankle sprain/strain. 12. Left ankle tenosynovitis. According to progress report 08/14/2013 by [REDACTED] the patient is status post right shoulder arthroscopy on 04/19/2013. The patient reported improvement with chiropractic and physical therapy treatments for the right shoulder. Recommendation was for patient to continue chiropractic and physical therapy treatments for the right shoulder 3 times a week for 4 weeks. The patient also complains of chronic knee pain. According to the 11/25/2013 progress report, the patient presents with continued right shoulder symptoms. The patient also complains of depression and sleeping problems. The patient was started on a course of physiotherapy and chiropractic treatments but reports that she has not been able to return to the recommended postsurgical treatments for the right shoulder due to transportation problems. The treater recommends "extracorporeal shock wave therapy for the left knee x3." He also recommends "treatment course consisting of chiropractic manipulative therapy and multimodality adjunctive physiotherapy." Utilization review from 01/24/2014 reviewed the requests as "Chiropractic consultation, Physiotherapy/chiro visit/follow-up and Extracorporeal shock wave therapy to the left knee."

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC CONSULTATION: 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): 58-59.

Decision rationale: This patient is status post right shoulder arthroscopy on 04/19/2013 and continues to be symptomatic. The medical record indicate the patient was prescribed post-operative physical therapy and chiropractic treatments. The number of post op treatments originally prescribed are unnoted. On 08/14/2013 patient was prescribed 3x4 physical therapy and chiro visits as the patient reported "improvement" with prior treatments. Report 11/25/2013 states patient was unable to complete recommended post op therapy due to transportation issues. The medical file provided for review does not provide any chiropractic or physical therapy reports. It is unclear how many chiro treatments the patient has had and how many more visits the treater is requesting. The MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. On 08/14/2013 the treater reported "improvement" with chiropractic treatments. In this case, the treater's statement of improvement does not substantiate functional improvement as required by MTUS. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior chiropractic treatments, recommendations for denial.

PHYSIOTHERAPY/CHIRO VISIT/FOLLOW UP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: This patient is status post right shoulder arthroscopy on 04/19/2013 and continues to be symptomatic. The medical records indicate the patient was prescribed post-operative physical therapy and chiropractic treatments. The number of post op treatments originally prescribed are unnoted. On 08/14/2013 patient was prescribed 3x4 physical therapy and chiro visits as the patient reported "improvement" with prior treatments. Report 11/25/2013 states patient was unable to complete recommended post op therapy due to transportation issues. The medical file provided for review does not provide any chiropractic or physical therapy reports. It is unclear how many physical therapy treatments the patient has had and how many more visits the treater is requesting. This patient is out of the post surgical time frame; therefore, post-surgical physical medicine guidelines will not be utilized. For physical medicine, the MTUS guidelines recommends for myalgia and myositis type symptoms, 9-10 visits over 8

weeks. In this case, additional sessions may have been warranted if the treater provided prior treatments received and their outcomes and the number of sessions being requested. A recommendation cannot be made on an open-ended request for physical therapy without specifying the duration and number of sessions. Recommendation is for denial.

EXTRACORPOREAL SHOCKWAVE THERAPY TO THE LEFT KNEE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College Of Occupational And Environmental Medicine (ACOEM) ,pg. 235, ESWT.

Decision rationale: This patient is status post right shoulder arthroscopy on 04/19/2013 and continues to be symptomatic. The patient also presents with chronic knee pain. The ACOEM Guidelines page 235 states the following regarding ESWT, "Published randomized clinical trials are needed to provide better evidence for the use of many physical therapy modalities that are commonly employed. Some therapists use a variety of procedures. Conclusions regarding their effectiveness may be based on anecdotal reports or case studies. Included among these modalities is extracorporeal shockwave therapy (ESWT)." The ODG Guidelines has the following regarding ESWT, "not recommended using high energy ESWT." The ODG regarding ESWT specifically for the knee/leg states, "Under study for patellar tendinopathy and for long bone hypertrophic non-unions." In this case, ACOEM and ODG Guidelines do not support the use of ESWT for knee conditions. It is considered anecdotal and is still considered under study. Recommendation is for denial.