

<b>Case Number:</b>	CM14-0203955		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	05/29/2009
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	10/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 56 year old patient with date of injury of 05/29/2009. Medical records indicate the patient is undergoing treatment for chronic cervical spine herniated nucleus pulposus with radiculopathy, chronic bilateral shoulder tendonitis, chronic bilateral lateral epicondylitis, chronic carpal tunnel syndrome, chronic lumbar spine herniated nucleus pulposus with radiculopathy, stress, anxiety and depression and uncontrolled diabetes. Subjective complaints include neck pain, described as constant, sharp and stabbing with radiation to bilateral upper extremities with numbness and tingling to hands, weakness in upper extremities; left shoulder pain described as sharp and stabbing rated 8/10; right shoulder pain described as constant, bilateral hand pain with numbness and tingling, elbow pain described as sharp and stabbing, difficulty sleeping, headaches, stress, anxiety, depression; lumbar spine pain described as sharp, stabbing and severe, radiating to bilateral lower extremities, right greater than left. Objective findings include cervical spine range of motion (ROM) - flexion and extension 40 degrees, left and right lateral flexion 20, right and left rotation 70; palpation of cervical spine revealed spinal tenderness bilaterally, anterior scalene bilaterally and trapezius musculature bilaterally; Cervical distraction, Maximum Foraminal Compression and shoulder decompression, Adson's tests positive; sensation to dorsum of right hand and posterior forearm on left diminished; palpation of bilateral upper extremities reveal tenderness to AC joint, capsule and soft tissue on the right, subacromial space, soft tissue and osseous structures on left; left shoulder range of motion 0 abduction 160 degrees, adduction 10, forward flexion 160, extension 30, internal rotation, 500, external rotation 60; right shoulder ROM - abduction 160 degrees, adduction 10, forward flexion 170, extension 30, internal rotation 70, external rotation 80; Supraspinatus, Impingement and Speed's Sign positive on right; Apley's Scratch, Impingement and Duga's test positive on left; Phalen's and Finkelstein's test positive bilaterally, Tinel's positive on right; lumbar spine ROM

flexion - 40, extension 10, right and left lateral flexion 20 and right and left rotation 20; Kemp's, Milgram's, Valsalva, Braggard's and Lasegue's test positive bilaterally. MRI of cervical spine dated 09/07/2014 revealed 4 mm disc herniation at C5-C6 and C6-C7. Treatment has consisted of lumbar epidural steroid injection, physical therapy, trigger point injections, TENS unit, acupuncture, use of walker. The utilization review determination was rendered on 10/31/2014 recommending non-certification of Physical therapy cervical spine 2 times a week for 3 weeks, Extracorporeal shockwave therapy for the cervical spine for six office visits and Extracorporeal shockwave therapy for the left wrist for six office visits.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy cervical spine 2 times a week for 3 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Physical Therapy, ODG Preface - Physical Therapy.

**Decision rationale:** The MTUS refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. The ODG writes regarding neck and upper back physical therapy, "Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion." The ODG further quantifies its cervical recommendations with Cervicalgia (neck pain); Cervical spondylosis = 9 visits over 8 weeks Sprains and strains of neck = 10 visits over 8 weeks Regarding physical therapy, the ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Medical records indicate that this patient has attended multiple physical therapies in the past. This patient's injury occurred over 5 years ago, and the treating physician has not indicated any new injury that would indicate the need for more physical therapy. As such, the request for Physical therapy cervical spine 2 times a week for 3 weeks is not medically necessary.

**Extracorporeal shockwave therapy for the cervical spine for six office visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, ESWT.

**Decision rationale:** The MTUS does not specifically refer to Electric Shockwave therapy. The medical records do not detail what conservative therapy was tried and do not provide any detail regarding the physical therapy of the shoulder. The ODG does not specify shock wave therapy for cervical neck, but does detail therapy of lumbar spine, "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." Medical documents do not provide sufficient details of failed conservative therapy for the cervical spine and guidelines do not recommend shock wave therapy for lumbar spine. As such, the request for extracorporeal shockwave therapy for the cervical spine for six office visits is not medically necessary.

**Extracorporeal shockwave therapy for the left wrist for six office visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist, ESWT; pub med search ESWT and wrist.

**Decision rationale:** The medical records do not detail what conservative therapy was tried and do not provide any detail regarding the physical therapy of the wrist. The ODG does not specify shock wave therapy for wrist and cervical neck, but does detail therapy of lumbar spine, "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." The medical documents do not provide sufficient details of failed conservative therapy for the wrist. As such, the request for extracorporeal shockwave therapy for the left wrist for six office visits is not medically necessary.