

Case Number:	CM15-0144513		
Date Assigned:	08/05/2015	Date of Injury:	05/11/2015
Decision Date:	09/23/2015	UR Denial Date:	07/15/2015
Priority:	Standard	Application Received:	07/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 41 year old woman sustained an industrial injury on 5-11-2015. The mechanism of injury is not detailed. Diagnoses include cervical myofasciitis, cervical radiculitis, thoracic myofasciitis, lumbar facet inducer vs. discogenic pain, bilateral epicondylitis, bilateral carpal tunnel syndrome, left knee internal derangement, bilateral hyperpronation of feet, anxiety, depression, and insomnia. Treatment has included oral medications. Physician notes dated 6-17-2015 show complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Recommendations include chiropractic care, extracorporeal shock wave therapy, cervical spine x-rays, thoracic spine x-rays, lumbar spine x-rays, left shoulder x-rays, bilateral elbow x-rays, bilateral wrist x-rays, left knee x-rays, cervical spine MRI, lumbar spine MRI, left shoulder MRI, left knee MRI, electromyogram and nerve conduction studies of the bilateral upper and lower extremities, general medicine consultation, podiatry consultation, acupuncture, an follow up with treating physicians.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shockwave Therapy for the left knee once a week for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235.

Decision rationale: The current request is for Extracorporeal Shockwave Therapy for the left knee once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. The ACOEM chapter 10 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 under the knee chapter on Extracorporeal Shockwave Therapy states, "Under study for patellar tendinopathy and for long-bone hypertrophic non-unions. Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping." According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. The treater has requested ESWT for the left knee. In this case, ACOEM and ODG Guidelines do not support the use of ESWT for knee conditions. This request is not medically necessary.

Electric Stimulation once a week for four weeks: 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 Transcutaneous electrotherapy Page(s): 114.

Decision rationale: The current request is for Electric Stimulation once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. MTUS, under Neuromuscular electrical stimulation (NMES devices) page 67 states, See Transcutaneous electrotherapy. MTUS, under Transcutaneous electrotherapy, page 114 states, Electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. The earliest devices were referred to as TENS (transcutaneous electrical nerve stimulation) and are the most commonly used. It should be noted that there is not one fixed electrical specification that is standard for TENS; rather there are several electrical specifications. Other devices (such as H- wave stimulation (devices), Interferential Current Stimulation, Microcurrent electrical

stimulation (MENS devices), RS-4i sequential stimulator, Electroceutical Therapy (bioelectric nerve block), Neuromuscular electrical stimulation (NMES devices), Sympathetic therapy, Dynatron STS) have been designed and are distinguished from TENS based on their electrical specifications to be discussed in detail below. ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter, under Electrical muscle stimulation (EMS) Section states, "Not recommended. The current evidence on EMS is either lacking, limited, or conflicting. There is limited evidence of no benefit from electric muscle stimulation compared to a sham control for pain in chronic mechanical neck disorders (MND). Most characteristics of EMS are comparable to TENS. The critical difference is in the intensity, which leads to additional musclecontractions. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999)" According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. The treater does not specify what type of electric stimulation is being requested. EMS or electrical muscle stimulator, also known as NMES is specifically not recommended for chronic pain. Additionally, treater has not provided reason for the request, nor documented objective progress towards functional restoration. This request is not medically necessary.

Therapeutic Exercises once a week for four weeks: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-189.

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

Decision rationale: The current request is for Therapeutic Exercises once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. The MTUS Chronic Pain Management Guidelines, pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. The patient has a relatively new injury and has been only treated with medication so far. There is no indication that physical therapy has been tried. Given the patient's pain and examination findings, a course of 4 PT sessions is within MTUS guidelines. This request is medically necessary.

Massage Therapy once a week for four weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: The current request is for Massage Therapy once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. MTUS Guidelines page 60 on Massage Therapy states that it is recommended as an option and as an adjunct with other recommended treatments such as exercise and should be limited to 4 to 6 visits. Massage is a passive intervention and treatment, dependence should be avoided. According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. The patient has a relatively new injury and has been treated only with medication so far. There is no indication that massage therapy has been tried. Given the patient's pain and examination findings, a course of 4 sessions is within MTUS guidelines. This request is medically necessary.

CMT 5 Regions once a week for four weeks: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The current request is for CMT 5 Regions once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. MTUS Guidelines, pages 58-59, Manual therapy & manipulation Section 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. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. In this case, there is no indication that the patient has tried Chiropractic therapy and MTUS supports an initial trial of six sessions. This request is reasonable and supported by MTUS. This request is medically necessary.

Extraspinal Manipulation with spinal once a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The current request is for Extraplinal Manipulation with spinal once a week for four weeks. The RFA is dated 06/26/15. Treatment has included oral medications. The patient remains off work. MTUS Guidelines, pages 58-59, Manual therapy & manipulation Section 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. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. According to progress report 6-17-2015, the patient complaints of neck pain, left shoulder pain, bilateral elbow pain, bilateral wrist and hand pain with numbness and tingling, upper back pain, low back pain, left knee pain, with sleep problems, anxiety, depression, headaches, stress, abdominal pain, and chest pain. Examination of the knee revealed decreased ROM with pain. In this case, there is no indication that the patient has tried Chiropractic therapy and the chiro treatments requested above has been authorized; therefore additional treatments would not be indicated until functional improvement is documented. This request is not medically necessary.