

Case Number:	CM14-0002611		
Date Assigned:	01/29/2014	Date of Injury:	03/31/2013
Decision Date:	06/16/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/07/2014

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 licensed in Chiropractic, and is licensed to practice in Arkansas, California, and Missouri. 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 35-year-old male, who injured his back and knees on March 31, 2013 from bending, pushing, pulling and heavy lifting of aluminum columns while making walls and furniture. The Doctor's First Report of Occupational Injury or Illness reports the patient presented for chiropractic care on November 05, 2013 with complaints of back pain, bilateral knee pain, anxiety, and stress. The physical examination revealed tenderness, muscle spasm and hypomobility in the thoracic and lumbar spines with reduced thoracolumbar ranges of motion. No measured objective factors were noted. The patient was diagnosed with thoracic sprain/strain, thoracic myofasciitis, thoracic facet induced versus discogenic pain, lumbar sprain/strain, lumbar myofasciitis, sacroiliac joint dysfunction/sprain/strain, lumbar facet induced versus discogenic pain, and bilateral lumbar radiculitis/sciatica, left knee patella tendinitis, bilateral knee internal derangement, and plantar fasciitis. There was a recommendation for chiropractic treatment to include manipulation to the thoracic and lumbar spines and bilateral knees, myofascial release, hydrocollator/cryotherapy, electrical stimulation, infrared, therapeutic exercise, back brace and other appropriate physiotherapeutic modalities at a frequency of 2 times per week for 4 weeks. The patient underwent chiropractic reevaluation on January 03, 2014 with complaints of continued back and knee pain. With the exception of patient age and dynamometer grip strength measurements, no measured objective factors were noted. The patient was to remain off-work until 02/19/2014. A treatment plan of 1 time per week for 4 weeks was recommended. Numerous therapy modalities were noted and included myofascial release, hot pack, mechanical traction, EMS, paraffin bath, ultrasound, massage therapy, and therapeutic exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC CONSULTATION, PHYSIOTHERAPY, CHIROPRACTIC VISIT/FOLLOW-UP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines Chronic Pain Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-25, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation, Physical Medicine Page(s): 58-59, 98-99.

Decision rationale: The requested chiropractic consultation is not supported by the ACOEM Guidelines. According to guidelines the documentation should include an inquiry focused on the patient's past medical history, record of the patient's estimate of activity tolerance given his or her symptoms, determination whether the patient's reported injury or illness is correlated now or in the past with a certain vocational or avocational activity; nature of symptoms such as changes in symptoms since onset - means of increasing or decreasing symptoms and limitation of function at home, at work, or in other situations; past history of and therapy for similar complaints; results of previous tests, treatments, and procedures; other physicians or practitioners seen for this or similar complaints. The patient's injury occurred on March 31, 2013 and he presented for chiropractic care on November 05, 2013. The above-referenced criteria were not reported; therefore, the requested chiropractic consultation is not supported. The request for chiropractic treatment (manual therapy & manipulation) at a frequency of two times per week for 4 weeks is not supported to be medically necessary. The California MTUS (Chronic Pain Medical Treatment Guidelines) supports a 6-visit trial of manual therapy and manipulation over 2 weeks in the treatment of chronic pain if caused by musculoskeletal conditions. With evidence of objective functional improvement with care during the 6-visit treatment trial, a total of up to 18 visits over 6-8 weeks may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups, there is the need to evaluate prior treatment success, if RTW (return to work) then 1-2 visits every 4-6 months. The request for eight chiropractic treatment sessions over 4 weeks exceeds guidelines recommendations and is not medically necessary.

EXTRACORPOREAL SHOCKWAVE THERAPY AS APPROPRIATE: 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), Treatment Index, 11th Edition, 2013, Low Back Chapter, Shockwave Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic), Procedure Summary - Extracorporeal Shock Wave Therapy (ESWT), Updated 03/31/2014. Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic),

Decision rationale: The Californis MTUS Chronic Pain Medical Treatment Guidelines and American College of Occupational and Environmental Medicine (ACOEM) do not discuss Extracorporeal Shockwave Therapy; therefore, the Official Disability Guidelines (ODG) is the reference source. In the Low Back - Lumbar & Thoracic (Acute and Chronic) section, ODG reports, shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the Knee & Leg (Acute and Chronic) section, ODG reports, that extracorporeal shock wave therapy (ESWT) is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. New data presented at the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy. Extracorporeal shockwave therapy is not supported in the treatment of low back conditions, and the patient has not been diagnosed with long-bone hypertrophic non-union. Therefore, the requested extracorporeal shock wave therapy is not medically necessary.