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| Case Number: | CM14-0131600 | | |
| Date Assigned: | 09/19/2014 | Date of Injury: | 12/24/2006 |
| Decision Date: | 10/22/2014 | UR Denial Date: | 08/18/2014 |
| Priority: | Standard | Application Received: | 08/18/2014 |

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 Family Medicine and is licensed to practice in Georgia. 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 37 year old male who was injured on December 24, 2006 when he fell 15 feet while cleaning a machine, landing on his buttocks while at work. His medication history includes tramadol. He has been treated conservatively with physical therapy and chiropractic treatment (number of sessions completed are unknown as only a single Physical Therapy eval note was provided). Progress report dated 08/01/2014 is handwritten and illegible other than a note that the patient "does not want epidural." Progress report dated 08/05/2014 is handwritten and largely illegible. It is noted the patient "is not interested in L/S epidural" recommended by his pain management physician. Sensation at the right lateral thigh, ankle, and calf were intact. Treatment requests were placed for Shockwave therapy, Physical Therapy, and chiropractic treatments 2 x/week for 6 weeks. Listed diagnoses included cervical spine disc bulges, thoracic spine strain, lumbar spine disc bulge with radicular pain, right wrist/hand strain, left wrist/hand strain. Physical therapy note dated 8/21/2014 indicated the patient presented with complaints of intermittent low back pain that increased with movement in small spaces and repetition. The patient also complained of neck and shoulder tightness that made its hard for him to relax. The patient rated his lumbar and neck pain as a 6-7/10. According to the patient squatting, lifting, pushing-pulling, bending, sit to stand, and prolonged activities increased his pain. Objective findings during lumbar examination revealed active flexion 60 degrees , manual muscle testing of the core core 3+/5, special testing revealed core weakness and l pelvic asymmetry , tenderness to palpation at the lumbar paraspinals, piriformis, and bilateral hamstrings. Extension was 10, sciatic nerve tension, left rotation 70, right rotation 60. Thoracic examination revealed active range of motion of 30 degrees with, MMT of the core 3+/5, special testing revealed core weakness. The patient was tender to palpate at the thoracic paraspinals and intrascapular region. Extension of the thoracic spine was 0, left rotation 15, right rotation 60. Cervical examination

revealed active flexion of 60 degrees , MMT of the deep neck flexors 3+/5. No cervical ligament instability was noted. There was tenderness to palpate at the cervical paraspinals, bilateral upper trapezius, levator and sub-occipitals. Extension was 0 degrees, left rotation 15, right rotation to 70. Prior utilization review dated August 18, 2014 indicated the request for Shockwave therapy for lumbar spine quantity: 6.00; request for Physical Therapy for cervical, thoracic and lumbar spine quantity: 12.00 and the request for Chiropractic treatment for cervical, thoracic and lumbar spine quantity: 12.00 were denied as medical necessity had not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy for lumbar spine QTY: 6.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment Integrated Treatment /Disability Duration Guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 5/10/13)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Elbow Complaints, Extracorporeal Shockwave Therapy Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Knee & Leg, Shoulder, Elbow-- Extracorporeal Shockwave Therapy (ESWT)

Decision rationale: The Official Disability Guidelines (ODG) address the use of extracorporeal shockwave therapy (ESWT) in relation to the elbow, shoulder, knee, ankle and foot. It does not directly address it in the context of the spine. A review of Pubmed for the use of ESWT in the spine yielded zero high quality randomized controlled trials or prospective studies of any kind. MTUS does not address the use of ESWT. Based on the available information and the lack of high quality clinical evidence to suggest efficacy of ESWT in the setting of low back pain, the request is deemed not medically necessary.

Physical Therapy for cervical, thoracic and lumbar spine QTY: 12.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines; Physical Medicine Page(s): page.

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

Decision rationale: The Official Disability Guidelines (ODG) recommends physical therapy. Evidence most strongly supports active therapy rather than extensive use of passive modalities. Physical therapy was slightly more effective than chiropractic treatment for chronic cases of low back pain. ODG recommends 10 visits over 8 weeks for lumbar and sacroiliac sprains and strains, as well as for intervertebral disc disorders, and spinal stenosis. 9 visits over 8 weeks is recommended for intervertebral disc disorders with or without myelopathy. 10-12 visits over 8

weeks is recommended for sciatica. ODG also recommends for fading of treatment frequency from up to 3-visits per week to 1-visit per week, plus active self directed home PT. For the neck, physical therapy is recommended by ODG. For cervical disc disorders, 10-12 visits over 8-weeks is recommended. Medical records document an initial PT evaluation. There are no records to indicate if the patient completed other visits beyond this initial evaluation. Based on the ODG guidelines and criteria stated above, the request for physical therapy, is medically necessary.

Chiropractic treatment for cervical, thoracic and lumbar spine QTY: 12.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines; Physical Medicine Page(s): page.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and Manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, Manual therapy and Manipulation.

Decision rationale: The Official Disability Guidelines (ODG) recommends manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. The intended goal of manual therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Chiropractic manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond anatomic range of motion. Specifically, manual therapy and manipulation are recommended as an option for treatment of low back pain. It is recommended for therapeutic care for a trial of 6-visits over 2-weeks. If there is evidence of objective functional improvement, a total of 18 visits over 6-8 weeks is recommended. Elective/maintenance care is not medically necessary. Treatment for recurrence/flare if initial treatment was successful in resulting in return to work is recommended for 1-2 visits every 4-6 months. Maximum recommended duration for the initial course is 8-weeks, with a recommendation to reevaluate the patient at that point. Continuation beyond 8-weeks may be indicated in some cases at 1-treatment per week until MMI is reached. The medical records document pathologies of the lumbar and cervical spine which meet criteria for chiropractic treatment, including disc related disorders of the cervical and lumbar spine, and thoracic strain. Based on the ODG guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.