

Case Number:	CM14-0134111		
Date Assigned:	09/18/2014	Date of Injury:	05/08/2014
Decision Date:	10/16/2014	UR Denial Date:	07/25/2014
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 Preventive Medicine 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:

According to the records made available for review, this is a 41-year-old male with a 5/8/14 date of injury. At the time (7/2/14) of request for authorization for 12 Sessions of physical therapy to the cervical spine, thoracic spine, lumbar spine, bilateral knees & bilateral upper extremities and extracorporeal shockwave to the left elbow and cervical spine, there is documentation of subjective complaints of pain in the neck, mid/upper back, lower back, bilateral upper extremities, and bilateral knees. The objective findings include tenderness over the cervical, thoracic, lumbar, bilateral upper extremities, and bilateral knees, positive cervical compression test, decreased thoracic, lumbar, and shoulder range of motion, positive bilateral straight leg raising test, positive impingement sign, positive McMurray's Test, and positive Tinel's sign. The current diagnoses are cervical spine musculoligamentous strain/sprain with radiculitis, thoracic spine musculoligamentous strain/sprain, and lumbar spine musculoligamentous strain/sprain with radiculitis, right shoulder impingement syndrome, right shoulder tendinitis, bilateral elbow sprain/strain, bilateral elbow lateral epicondylitis, and bilateral knee sprain/strain. The treatments to date include medications, previous extracorporeal shockwave treatment, and 8 previous physical therapy treatments. Regarding physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Sessions of physical therapy to the cervical spine, thoracic spine, lumbar spine, bilateral knees & bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Shoulder, Low Back AND Neck and Upper Back, Physical therapy (PT) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Official Disability Guidelines (ODG) recommends a limited course of physical therapy for patients with diagnoses of sprains and strains of knee and leg; brachia neuritis or radiculitis NOS; and Sciatica. Thoracic/lumbosacral neuritis/radiculitis not to exceed 12 visits over 8 weeks, with a diagnosis of Impingement syndrome not to exceed 10 visits over 8 weeks, and with a diagnosis of Lateral epicondylitis not to exceed 8 visits over 5 weeks. ODG also notes 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) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical spine musculoligamentous strain/sprain with radiculitis, thoracic spine musculoligamentous strain/sprain, and lumbar spine musculoligamentous strain/sprain with radiculitis, right shoulder impingement syndrome, right shoulder tendinitis, bilateral elbow sprain/strain, bilateral elbow lateral epicondylitis, and bilateral knee sprain/strain. In addition, there is documentation of 8 previous physical therapy treatments, functional deficits, and functional goals. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. In addition, the requested number of treatments, in addition to the treatments already completed, would exceed guidelines. Therefore, based on guidelines and a review of the evidence, the request for 12 Sessions of physical therapy (PT) to the cervical spine, thoracic spine, lumbar spine, bilateral knees & bilateral upper extremities is not medically necessary.

Extracorporeal shockwave to the left elbow and cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 11th Edition

(web 2014) Treatment section for the elbow under the heading of Extracorporeal Shockwave Therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203; 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter, Extracorporeal Shock Wave Therapy (ESWT)

Decision rationale: MTUS reference to ACOEM Guidelines identifies a recommendation against using extracorporeal shockwave therapy for evaluating and managing elbow complaints. In addition, specifically regarding the cervical spine, MTUS and Official Disability Guidelines (ODG) do not address the issue, a search of the National Guideline Clearinghouse did not provide any guidelines addressing the issue, and an online search did not provide any articles/studies addressing the issue. Analogously, ODG identifies that the available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Therefore, based on guidelines and a review of the evidence, the request for extracorporeal shockwave to the left elbow and cervical spine is not medically necessary.