

<b>Case Number:</b>	CM14-0213337		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	03/20/2014
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 55 year old male with a date of injury of 3/20/14. He is being treated for lumbar disc protrusion, lumbar myofasciitis, lumbar sprain/strain, sciatica, right shoulder myoligamentous injury and right should sprain/strain. Subjective findings on 10/25/14 include dull, sharp low back pain with heaviness and numbness radiating into the left leg and constant dull achy right shoulder pain and stiffness. Objective findings include decreased lumbar spine ROM, paravertebral muscle tenderness, decrease right should ROM with flexion at 140 degrees, tenderness on palpation of anterior shoulder and + Neer's test. Previous treatments have included home exercises, and medications (ibuprofen) acupuncture (6 sessions) and physical therapy (6 sessions). The Utilization Review on 10/25/14 found the request for Acupuncture 1 time per week for 6 weeks for the lumbar spine and right shoulder, Chiropractic 1 time per week for 6 weeks for the lumbar spine and right shoulder, Extracorporeal shockwave therapy (ESWT) 2 times per week for 6 weeks for the lumbar spine, Physical Therapy 1 time per week for 6 weeks for the lumbar spine and right shoulder and Cold / Heat Therapy 2 times a week for 10 weeks - 20 mins (rental) for the lumbar spine and right shoulder to be non-certify with a modification for Acupuncture 1 time per week for 6 weeks for the lumbar spine and right shoulder to be certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 1 time per week for 6 weeks for the lumbar spine and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 9 Shoulder Complaints Page(s): 114, 204, 298-299, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (Shoulder Chapter; [http://www.anthem.com/medicalpolicies/policies/mp\\_pw\\_a050255.htm3](http://www.anthem.com/medicalpolicies/policies/mp_pw_a050255.htm3) ; [http://www.aetna.com/cpb/medical/data/600\\_699/0649.html](http://www.aetna.com/cpb/medical/data/600_699/0649.html) ; [http://www.aetna.com/cpb/medical/data/200\\_299/0297.htm](http://www.aetna.com/cpb/medical/data/200_299/0297.htm);

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Acupuncture; Shoulder, Acupuncture

**Decision rationale:** MTUS "Acupuncture Medical Treatment Guidelines" clearly state that "acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." The medical documents did not provide detail regarding patient's increase or decrease in pain medication. Further, there was no evidence to support that this treatment would be utilized as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. ODG does not recommend acupuncture for acute low back pain, but "may want to consider a trial of acupuncture for acute LBP if it would facilitate participation in active rehab efforts." The initial trial should "3-4 visits over 2 weeks with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)" There is evidence provided that indicates the patient received acupuncture before but it is unclear as to how much functional improvement was made. It is also unclear if the sessions are being used as an adjunct to physical rehabilitation or surgical intervention. As such, the request for acupuncture for 1 times a week for 6 weeks is not medically necessary.

**Chiropractic 1 time per week for 6 weeks for the lumbar spine and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation. Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

**Decision rationale:** ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic

care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." In this case, the patient is well out of the acute phase of his low back and shoulder pain syndrome time periods, making chiropractic services less helpful in treating his symptoms. As such, the request for chiropractic services is not medically necessary.

**Extracorporeal shockwave therapy (ESWT) 2 times per week for 6 weeks for the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[http://www.anthem.com/medicalpolicies/policies/mp\\_pw\\_a050255.htm3](http://www.anthem.com/medicalpolicies/policies/mp_pw_a050255.htm3)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Pubmed, UpToDate

**Decision rationale:** Neither the MTUS nor ODG address extracorporeal shockwave therapy (ESWT) use in the lumbar spine. An extensive review of the literature through PubMed and UpToDate fail to reveal any guidelines on its use, review articles and the likewise. A systemic review is available by [REDACTED] which states, "available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. High-quality RCTs are needed to assess their efficacy versus appropriate sham procedures, and their effectiveness and cost-effectiveness versus other procedures shown to be effective for LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged."As such, the request for Extracorporeal shockwave therapy (ESWT) 2 times per week for 6 weeks for the lumbar spine is not medically necessary.

**Physical Therapy 1 time per week for 6 weeks for the lumbar spine and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation CA MTUS ACOEM Pain, Suffering and the Restoration of Function Chapter (page 114)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine. Page(s): 98-99.

**Decision rationale:** California MTUS guidelines 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. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified

backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate what initial trial was used and what the results were. There is no documented active self-directed home Physical Medicine program. As such, the request for Physical Therapy 1 time per week for 6 weeks for the lumbar spine and right shoulder is not medically necessary.

**Cold / Heat Therapy 2 times a week for 10 weeks - 20 mins (rental) for the lumbar spine and right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation  
[http://www.aetna.com/cpb/medical/data/200\\_299\\_0297.html](http://www.aetna.com/cpb/medical/data/200_299_0297.html)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support Other Medical Treatment Guideline or Medical Evidence: <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy-coldtherunit>

**Decision rationale:** MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)". The use of devices that continuously circulate a cooled solution via a refrigeration machine have not been shown to provide a significant benefit over ice packs. There is even less data when it comes to units which alternate between a heated and then a cooled solution. As such the request for Cold / Heat Therapy 2 times a week for 10 weeks - 20 mins (rental) for the lumbar spine and right shoulder is not medically necessary.