

Case Number:	CM15-0143831		
Date Assigned:	08/10/2015	Date of Injury:	06/22/2012
Decision Date:	11/02/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/24/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 injured worker is a 46 year old female, who sustained an industrial injury on 6-22-12. The injured worker is undergoing treatment for cervical, bilateral shoulder, bilateral elbow, bilateral wrist and right knee strain-sprain. Medical records dated 5-12-14 indicate the injured worker complains of neck stiffness, shoulder pain, right elbow discomfort, right wrist weakness, left wrist numbness and right knee pain. Physical exam (5-12-14) notes para cervical tenderness to palpation with painful cervical compression, bilateral shoulder tenderness to palpation and painful Yergason's and Speed's, bilateral elbow tenderness to palpation and painful Cozen's, bilateral wrist tenderness to palpation with painful Tinel's, Phalen's and Finkelstein's and right knee tenderness to palpation with painful McMurray's. Medical record dated 12-1-14 indicates magnetic resonance imaging (MRI) studies of the neck, low back, hips hands, knees and ankles "revealed that all the body parts had positive findings" and "received physical therapy for all the affected body parts." Treatment included chiropractic treatment, anti-inflammatory and liquid pain medication and Tylenol with codeine. The original utilization review dated 7-6-15 indicates the request for retrospective extracorporeal shock wave therapy 1X6 for the cervical spine DOS 10-3-14, retrospective extracorporeal shock wave therapy 1X6 for the wrist DOS 9-4-14, retrospective chiropractic therapy 3X4 for the lumbar spine DOS 8-6-14, 7-9-14, retrospective 4 view X-ray of the lumbar spine DOS 7-15-14, retrospective 4 view X-ray of the cervical spine DOS 7-15-14, retrospective X-ray of the wrists DOS 7-15-14, and retrospective 4 view X-ray of the knees DOS 7-15-14 is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro ESWT 1 x 6 for the cervical spine, DOS: 10/3/2014: Upheld

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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS does not address this request. Per guidelines, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of Rotator cuff tendonitis associated with calcific deposits in the tendon (calcific tendonitis). It is recommended for use in patients, whose pain has remained despite six months of standard treatment and at least three conservative treatments, including rest, Ice, NSAIDs, Orthotics, Physical Therapy and Cortisone injections. Per guidelines, the injured worker's chronic neck condition does not fit the criteria for the recommendation of extracorporeal shock wave therapy (ESWT). The request for Retro ESWT 1 x 6 for the cervical spine, DOS: 10/3/2014 is not medically necessary.

Retro ESWT 1 x 6 for the wrist, DOS: 9/4/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Blue Cross: Medical Policy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: MTUS does not address this request. Per guidelines, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of Rotator cuff tendonitis associated with calcific deposits in the tendon (calcific tendonitis). It is recommended for use in patients, whose pain has remained despite six months of standard treatment and at least three conservative treatments, including rest, Ice, NSAIDs, Orthotics, Physical Therapy and Cortisone injections. Per guidelines, the injured worker's complain of chronic wrist pain does not fit the diagnostic criteria for Extracorporeal shock wave therapy (ESWT). The request for Retro ESWT 1 x 6 for the wrist, DOS: 9/4/2014 is not medically necessary.

Retro Chiropractic therapy 3 x 4 for the lumbar spine, DOS: 8/6/14, 7/9/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective/maintenance care is not medically necessary. Documentation shows that the injured worker complains of chronic low back pain, with lack of detailed information regarding previous conservative therapy, such as physical therapy or chiropractic treatment, including the number of visits or objective clinical outcome of the treatment. Physician reports also indicated that the injured worker had reached maximum medical therapy. The medical necessity for additional manual therapy has not been established. The request for Retro Chiropractic therapy 3 x 4 for the lumbar spine, DOS: 8/6/14, 7/9/14 is not medically necessary.

Retro 4 view X-ray of the lumbar spine, DOS: 7/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation at the time of the request under review fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms of low back pain to support the medical necessity for repeat X-rays. The request for Retro 4 view X-ray of the lumbar spine, DOS: 7/15/14 is not medically necessary per MTUS.

Retro 4 view X-ray of the cervical spine, DOS: 7/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends spine x rays in patients with neck pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. Documentation at the time of the request under review fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms. The medical necessity for additional imaging has not been established. The request for Retro 4 view X-ray of the cervical spine, DOS: 7/15/14 is not medically necessary.

Retro X-ray of the wrists, DOS: 7/15/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, and Wrist & Hand.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter, Radiography.

Decision rationale: MTUS states that for most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Per guidelines, the indications for X-rays of the hand or wrist include acute trauma, where there is suspicion for acute fracture or dislocation. The injured worker complains of chronic bilateral wrist pain. Documentation fails to show objective evidence indicating a significant change in symptoms or clinical findings to establish the medical necessity for plain X-rays. The request for Retro X-ray of the wrists, DOS: 7/15/14 is not medically necessary per guidelines.

Retro 4 view X-ray of the knees, DOS: 7/15/14: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends plain-film radiographs of the knee, and special imaging studies only after a period of conservative care and observation, and only when a red flag is noted on history or examination such as significant hemarthrosis or the inability to flex the knee to 90 degrees, raising suspicion of conditions including fracture. Documentation at the time of the requested service under review fails to show red flags on physical examination to support the medical necessity of a knee X-ray. The request for Retro 4 view X-ray of the knees, DOS: 7/15/14 is not medically necessary per MTUS.