

Case Number:	CM15-0066847		
Date Assigned:	04/14/2015	Date of Injury:	02/16/2011
Decision Date:	05/13/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/08/2015

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 Jersey

Certification(s)/Specialty: Family Practice

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 47-year-old female, who sustained an industrial/work injury on 2/16/11. She reported initial complaints of neck and back pain. The injured worker was diagnosed as having cervical spine/thoracic spine/lumbar spine herniated nucleus pulposus. Treatment to date has included medication, acupuncture, epidural steroid injection, aqua therapy, surgery (lumbar laminectomy 3/14/13), and physical therapy. Currently, the injured worker complains of persistent pain in the cervical and lumbar spine. Per the secondary physician's progress report (PR-2) on 3/11/15, there was tenderness with palpation to the left suboccipital region and at the right C3 and lumbosacral paraspinal tenderness and right sacrum tenderness. The requested treatments include Chiropractic therapy and Ortho shockwave therapy for the cervical and thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy once a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that for musculoskeletal conditions, manual therapy & manipulation is an option to use for therapeutic care within the limits of a suggested 6 visits over 2 weeks, with evidence of objective functional improvement, and a total of up to 18 visits over 6-8 weeks. It may be considered to include an additional 6 session (beyond the 18) in cases that show continual improvement for a maximum of 24 total sessions. The MTUS Guidelines also suggest that for recurrences or flare-ups of pain after a trial of manual therapy was successfully used, there is a need to re-evaluate treatment success, and if the worker is able to return to work then 1-2 visits every 4-6 months is warranted. Manual therapy & manipulation is recommended for neck and back pain, but is not recommended for the ankle, foot, forearm, wrist, hand, knee, or for carpal tunnel syndrome. In the case of this worker, there was a reported history of having completed some chiropractor treatment sessions, as much as 12 sessions. However, there was insufficient reporting found which clearly stated the functional gains and pain reduction as a result of these chiropractor sessions. Therefore, the request for additional sessions will be considered medically unnecessary without clear evidence of benefit with prior sessions.

Ortho shockwave therapy for the cervical and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back section, Shockwave therapy.

Decision rationale: The MTUS is silent regarding shock wave therapy for low back pain. The ODG, however, states that it is not recommended due to the available evidence not supporting the effectiveness of ultrasound or shock wave for treating back or neck pain. In the case of this worker, shock wave therapy is not indicated, considering the request was for neck and thoracic spine, both of which are not recommended body areas for this type of therapy. Also, there was no indication as to how many sessions were requested. Therefore, the request for ortho shockwave therapy for the cervical and thoracic spine will be considered medically unnecessary.