

<b>Case Number:</b>	CM13-0006042		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/12/2009
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	07/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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 injured worker is a 52-year-old female who reported an injury on 06/12/2009. The mechanism of injury was not provided for review. The injured worker ultimately underwent lumbar spinal fusion at the L5-S1 with decompression at the L4-5 followed by postoperative treatment to include shockwave therapy and postoperative physical therapy. The injured worker was evaluated on 06/28/2013. It was documented that the extracorporeal shockwave therapy was considered helpful to the lumbar spine; however, was not providing significant benefit to the injured worker's rotator cuff complaints. Physical examination findings included right shoulder tenderness over the acromioclavicular joint and anterior and lateral deltoid with restricted range of motion and a positive impingement sign, a positive near sign, and positive O'Brien's test. Physical evaluation of the lumbar spine documented pain and tenderness in the par lumbar musculature from the L4 to the S1 with significantly restricted range of motion and a positive straight leg rising testing bilaterally. The injured worker's diagnoses included status post right shoulder surgery, status post multiple lumbar spine surgeries, failed lumbar surgery syndrome. The injured worker's treatment plan included additional physical therapy, extracorporeal shockwave therapy, and other diagnostic studies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TWICE A WEEK FOR SIX WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**Decision rationale:** The requested physical therapy twice a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has participated in a course of postoperative physical therapy. California Medical Treatment Utilization Schedule recommends 26 visits of postoperative physical therapy following a fusion surgery. The clinical documentation does indicate that the injured worker has participated in at least 26 visits of physical therapy. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Additionally, there are no exceptional factors noted within the documentation to preclude the injured worker from further progress while participating in a home exercise program. As such, the requested physical therapy twice a week for 6 weeks is not medically necessary or appropriate.

**TRIAL OF EXTRACORPOREAL SHOCK-WAVE THERAPY FOR THE RIGHT SHOULDER AND LOW BACK:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER AND LOW BACK CHAPTER, EXTRACORPOREAL SHOCK-WAVE THERAPY.

**Decision rationale:** The requested trial of extracorporeal shockwave therapy for the right shoulder and low back is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this request. Official Disability Guidelines do not recommend extracorporeal shockwave therapy for any diagnoses of the shoulder aside from calcifying tendinosis. The clinical documentation does not provide evidence that the injured worker is diagnosed with calcifying tendinosis. Additionally, Official Disability Guidelines do not recommend the use of extracorporeal shockwave therapy for the low back. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested trial of extracorporeal shockwave therapy for the right shoulder and low back is not medically necessary or appropriate.

**FOLLOW-UP WITH [REDACTED] FOR CONTINUED OCCUPATIONAL MEDICINE INCLUDING FURTHER INJECTIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The requested follow-up with [REDACTED] for continued occupational medicine including further injections is not medically necessary or appropriate. American College of Occupational and Environmental Medicine recommends referral to specialist when a treatment plan is outside of the treating provider's scope of practice. The request indicates there is a referral for occupational medicine for further injections. However, there is no documentation that the injured worker is a candidate for additional injection therapy. No justification for the request was provided for review. As such, the requested follow-up with [REDACTED] for continued occupational medicine including further injections is not medically necessary or appropriate.