

Case Number:	CM13-0018687		
Date Assigned:	10/11/2013	Date of Injury:	08/08/2000
Decision Date:	01/17/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	08/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Oklahoma. 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 physician 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 patient is a 53-year-old female with a reported date of injury of 08/08/2000. The patient presented with neck pain radiating down the bilateral shoulders, arms, and hands, left shoulder pain radiating to the left side of the chest and left side of the neck, low back pain radiating down the right leg to the knee, a positive cervical compression test, a positive Jackson's, positive Romberg's, restricted cervical range of motion, a positive apprehension test in the shoulder, positive Neer sign in the left shoulder, a positive Hawkins sign in the left shoulder, restricted range of motion in the left shoulder, decreased sensation in the L5 dermatome, a positive Patrick's Faber, a positive Spurling's sign, a positive Hoffmann's, and limited range of motion in the lumbar spine. The patient had diagnoses including cervical intervertebral disc displacement without myelopathy, left upper extremity radiculopathy, status post arthroscopic repair, left shoulder, and lumbar intervertebral disc displacement without myelopathy. The physician's treatment included requests for 6 shockwave treatments of the cervical spine, lumbar spine, and right shoulder. ∂∂

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave Treatment x6 for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Extracorporeal shock wave therapy (ESWT.)

Decision rationale: The MTUS Chronic Pain Guidelines do not address shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the provided documentation, the Guidelines recommend the use of shockwave treatment for the shoulder; however, there are no indications for use in the cervical spine. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Additionally, the requesting physician's rationale for the request was unclear. Therefore, the request for Shockwave Treatment x6 or the cervical spine is not medically necessary and appropriate.

Shockwave treatment x6 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Shockwave therapy.

Decision rationale: The MTUS Chronic Pain Guidelines do not address shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note shockwave therapy is not recommended for treating lower back pain. The request for shockwave treatment x6 for lumbar is not medically necessary and appropriate

Shockwave treatment x3 for the right shoulder i: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Extracorporeal shock wave therapy (ESWT.)

Decision rationale: The MTUS Chronic Pain Guidelines do not address shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. The Official Disability Guidelines recommend a maximum of 3 therapy sessions over 3 weeks. Within the provided documentation, the requesting physician did not include a complete assessment of the right shoulder in order to demonstrate objective functional deficits needing to be addressed with the treatments. The prior courses of treatment for the right shoulder were unclear within the provided documentation. Additionally, the requesting physician's rationale for the request was unclear within the provided documentation. Therefore, the request for Shockwave treatment x3 for the right shoulder is not medically necessary and appropriate.