

Case Number:	CM13-0036070		
Date Assigned:	02/20/2014	Date of Injury:	09/30/2012
Decision Date:	05/23/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/18/2013

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 and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Illinois. 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 61-year-old male who reported an injury on 09/30/2012, secondary to a fall. The current diagnosis is right shoulder rotator cuff tear. The injured worker was evaluated on 08/08/2013. The injured worker has been previously treated with physical therapy and pain medication. The injured worker reported 9/10 right shoulder pain with radiation into the forearm and fingers as well as muscle spasm. Physical examination revealed 3+ tenderness to palpation at the supraspinatus tendon attachment sites, 2 +tenderness at the supraspinatus and infraspinatus muscles, limited range of motion, positive shoulder depression testing on the right, decreased grip strength on the right, intact sensation, and decreased strength in the C5 through T1 dermatomes. The treatment recommendations at that time included a course of shockwave therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXTRACORPOREAL SHOCKWAVE THERAPY ONCE A WEEK FOR TWELVE (12) WEEKS FOR RIGHT SHOULDER .: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

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

Decision rationale: The California MTUS/ACOEM Practice Guidelines state medium quality evidence supports manual physical therapy, ultrasound, and high energy for extracorporeal shockwave therapy for calcifying tendinitis of the shoulder. The Official Disability Guidelines (ODG) state extracorporeal shockwave therapy is recommended for calcifying tendinitis, but not recommended for other shoulder disorders. The treatment includes a maximum of three therapy sessions over three weeks. As per the documentation submitted, the injured worker does not maintain a diagnosis of calcifying tendinitis of the right shoulder. The current request for 12 sessions of extracorporeal shockwave therapy exceeds MTUS guideline recommendations. As such, the request for extracorporeal shockwave therapy once a week for twelve (12) weeks for the right shoulder is non-certified.