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| Case Number: | CM13-0038701 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 03/17/2011 |
| Decision Date: | 07/30/2014 | UR Denial Date: | 09/26/2013 |
| Priority: | Standard | Application Received: | 10/01/2013 |

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 Internal Medicine and is licensed to practice in California. 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 patient is an injured worker with a left shoulder condition. Date of injury was 03/17/2011. PR-2 progress report 09/10/2013 documented left shoulder discomfort and pain the left supraspinatus, and abduction 160 degrees, on physical examination. Diagnosis included left shoulder tenosynovitis. Extracorporeal shockwave procedure report 09/13/2013 and 09/20/13 documented a diagnosis of rotator cuff syndrome left shoulder. An operative Report dated 02/04/2013, documented post-operative diagnoses of left shoulder impingement syndrome with acromioclavicular joint pain with partial thickness rotator cuff tearing. Surgeries performed were left shoulder arthroscopic subacromial decompression, excisional acromioclavicular joint arthroplasty Mumford and a rotator cuff debridement. Utilization review dated 09/26/2013 recommended non-certification of the request for shockwave left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave treatment times one (1) to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation ODG-TWC Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Shoulder (Acute & Chronic) Extracorporeal shock wave therapy (ESWT) Recommended for calcifying tendinitis but not for other shoulder disorders.

Decision rationale: Medical treatment utilization schedule MTUS ACOEM 2nd Edition (2004) Chapter 9 Shoulder Complaints states that physical modalities are not supported by high-quality medical studies. Some medium quality evidence supports extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. The ODG Shoulder (Acute & Chronic) states that extracorporeal shock wave therapy (ESWT) is recommended for calcifying tendinitis but not for other shoulder disorders. A PR-2 progress report 09/10/2013 diagnosis left shoulder tenosynovitis. A procedure report 09/13/2013 and 09/20/13 documented diagnosis rotator cuff syndrome left shoulder. Operative Report 02/04/2013 documented post-operative diagnoses: left shoulder impingement syndrome with acromioclavicular joint pain with partial thickness rotator cuff tearing. The MTUS and ODG guidelines recommends extracorporeal shock wave therapy (ESWT) for calcifying tendinitis, but not for other shoulder disorders. No evidence of calcifying tendinitis was contained in the medical records. Therefore, MTUS and ODG guidelines and medical records do not support the medical necessity of extracorporeal shock wave therapy. Therefore, the request for Shockwave treatment to the left shoulder is not medically necessary.