

Case Number:	CM14-0005263		
Date Assigned:	01/24/2014	Date of Injury:	08/09/2010
Decision Date:	09/26/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/14/2014

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 Family 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:

This is a 38 year old female patient who reported an industrial injury on 8/9/2010, over four (4) years ago, attributed to the performance of customary job tasks reported as due to RSI. The patient was noted to have undergone a C5-C6 anterior cervical discectomy with fusion on 10/1/2012. The treating diagnoses included cervical spine sprain/strain; cervical spine canal narrowing; status post cervical spine surgery on 10/1/2012. The patient complained of right elbow pain. The objective findings on examination included tenderness to palpation to the right elbow. The treatment plan included extracorporeal shockwave therapy right elbow. The treating diagnoses included cervical spine strain/sprain; cervical spine DDD; cervical spine canal narrowing; status post cervical spine surgery; abdominal pain; left shoulder strain/sprain; right shoulder sprain/strain compensatory; left elbow strain/sprain; right elbow pain lateral epicondyles secondary to left ulnar dysfunction; bilateral wrist strain/sprain; bilateral carpal tunnel syndrome; sleep disturbance secondary to pain. The treatment plan included additional physical therapy; topical compounded analgesic cream; Medrox patches; and interferential muscle stimulators; urine toxicology testing and ECSWT for bilateral carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extra corporeal Shockwave Therapy right elbow: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235;29;203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder---ESWT.

Decision rationale: The request for ESWT to the right elbow does not provide any objective evidence to support the medical necessity of the requested ESWT. The patient is being treated for carpal tunnel syndrome with a reported lateral epicondylitis. There is no demonstrated evidence of a calcific tendinitis. The requested treatment is not demonstrated to be medically necessary and is not consistent with the recommendations of the CA MTUS. There is no rationale provided to support the medical necessity of the performed ESWT directed to the right elbow. The treatment of the wrists with ESWT is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines unless certain criteria are met with specific diagnoses. The provider did not provide any objective evidence to support the use of ESWT for the diagnosed right elbow epicondylitis pain that was demonstrated on the physical examination as only tenderness to palpation. There is no provided objective evidence that the use of ESWT for the symptoms related to the objective findings documented for this patient is medically necessary or leads to functional improvement. There is no demonstrated medical necessity for ESWT to the right elbow for this patient. The CA MTUS is silent on the use of ESWT. The Official Disability Guidelines only recommend the use of ESWT to the shoulder, elbow, and knee under certain clinical situations directed to the treatment of a calcific tendonitis or a prepatellar bursitis. It is not clear that the requesting provider has demonstrated a failure of conservative care and the decision to proceed with the requested treatment against the recommendations of the currently accepted guidelines is not demonstrated to be medically necessary. The use of conservative treatment must be performed for at least six (6) months with documentation of treatment failure. There is no demonstrated medical necessity for the ESWT directed to the right elbow. Given the above the request is not medically necessary.