MAXIMUS Federal Services

Case Number:	CM14-0105046		
Date Assigned:	07/30/2014	Date of Injury:	09/21/2012
Decision Date:	09/26/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	07/08/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 50 year-old individual was reportedly injured on September 21, 2012. The mechanism of injury is not listed in these records reviewed). The most recent progress note, dated July 3, 2014, indicates that there are ongoing complaints of neck and right shoulder pain. The physical examination demonstrated a decrease in cervical spine range of motion, a decrease in shoulder range of motion and no other findings are reported. Diagnostic imaging studies were not addressed. Previous treatment includes 3 sessions of extracorporeal shockwave therapy. A request had been made for shockwave therapy and was not certified in the pre-authorization process on June 6, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave to the right shoulder 1 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter updated August, 2014.

Decision rationale: It is noted that the ACOEM and MTUS do not address this device. Accordingly, the parameters noted in the ODG are employed. As noted in the ODG, shockwave therapy is for patients with a calcifying tendinitis. This individual is noted undergone a shoulder surgery some 18 months prior, but there is no data to suggest there is a calcific tendinitis. Furthermore, the records also noted 3 sessions of this therapy have been completed and there is no objectified efficacy, utility, increase functionality or decreased symptomology. Therefore, it is clear that this methodology is not effective. As such, there is no medical necessity for the continued use of this intervention. The request is not medically necessary and appropriate.

Physical Therapy 1 x 6 to the cervical spine and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

Decision rationale: As outlined in the ACOEM guidelines, there is support for physical therapy. However, when noting the date of injury, the injury sustained, the surgical intervention completed and the amount of physical therapy already completed, there is no indication for any additional formal physical therapy this time. Transition to home exercise protocol has been initiated and is all that would be supported. Therefore, when noting the current clinical situation tempered by the parameters outlined in the ACOEM guidelines, the medical necessity for additional physical therapy is not supported. The request is not medically necessary and appropriate.

Interferential (IF) Unit 2 month trial with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: As outlined in the MTUS, this is not supported as a isolated intervention. There is no noted trial of this device to establish the efficacy or utility. Therefore, without a trial the utilization and long-term or purchased is not supported in the guidelines. This is not medically necessary.