

Case Number:	CM14-0132259		
Date Assigned:	09/18/2014	Date of Injury:	08/22/2011
Decision Date:	10/16/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	08/18/2014

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 and Rehabilitation, has a subspecialty in Pain Management 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 female patient with a date of injury of August 22, 2011. A utilization review determination dated July 15, 2014 recommends non-certification of extracorporeal shockwave therapy times 3 for the right shoulder and an MRI of the left shoulder. A progress note dated June 11, 2014 identifies subjective complaints of pain in the neck, mid/upper back, lower back, bilateral shoulders/arms, and bilateral knees. The patient reports a pain level 8/10 in the neck and mid-/upper back, a pain level 9/10 in the lower back, a pain level of 7/10 in the right shoulder/arm, a pain level of 8 - 9/10 in the left shoulder, a pain level of 7 - 8/10 in the right knee, and the pain level of 8/10 in the left knee. Physical examination identifies grade 3 tenderness to palpation of bilateral shoulders that has remained the same since her last visit, there is restricted range of motion and impingement and supraspinatus tests are positive. The diagnoses include history of blurred vision, cervical spine strain/sprain with radiculitis, cervical spine discogenic disease, cervical spine radiculopathy, thoracic spine strain/sprain, lumbar spine strain/sprain with radiculitis, lumbar spine discogenic disease, lumbar spine radiculopathy, bilateral shoulder strain/sprain, rule out right shoulder rotator cuff tear, status post right shoulder surgery times 2 in 2002 and 2/2013, bilateral knee strain/sprain, rule out bilateral knee meniscal tear, sleep disturbance secondary to pain, and situational depression. The treatment plan recommends that the patient continue physical therapy of the cervical spine, lumbar spine, and bilateral shoulders two times a week for six weeks the patient has completed 13 sessions of physical therapy, the patient was prescribed topical medications, the patient was referred for an MRI of the left shoulder, the patient was referred for extracorporeal shockwave therapy of the right shoulder, and a urine toxicology test was administered for medication monitoring. An MRI of the left shoulder performed on June 21, 2014 identifies supraspinatus tendinosis with possibly a full thickness tear near the insertion. An MRI of the left shoulder performed on January 21,

2014 identifies a small focal full thickness tear of supraspinatus tendon on a background of tendinosis, mild strain of the deltoid muscle, and degenerative hypertrophic changes of the acromioclavicular joint. A procedure report identifies extracorporeal shockwave therapy performed on June 16, 2014 for the diagnosis of left shoulder impingement syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy times 3 to right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, Current Edition (web), current year, Shoulder: Extracorporeal shock wave therapy (ESWT):

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 Chapter, Extracorporeal Shockwave Therapy (ESWT)

Decision rationale: Regarding the request for extracorporeal shockwave therapy (ESWT) x3 of the right shoulder, ODG recommend for calcifying tendinitis but not for other shoulder disorders. In treating calcifying tendonitis, both high-energy and low-energy ESWT provide a beneficial effect on shoulder function, as well as on self-rated pain and diminished size of calcifications, but high-energy ESWT appears to be superior to low-energy ESWT. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions. The criteria for use of ESWT includes: Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment; At least three conservative treatments have been performed prior to use of ESWT. These would include: a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone); Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. Within the documentation available for review, there is no identification of a diagnosis of right shoulder calcifying tendinitis. As such, the current request for extracorporeal shockwave therapy (ESWT) x3 of the right shoulder is not medically necessary.

MRI of Left Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 7th Edition (web) 2012, Shoulder, MRI scan:

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Magnetic resonance imaging (MRI)

Decision rationale: Regarding the request for MRI of the left shoulder, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or acromioclavicular (AC) joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, there are reports of two MRI's performed on January 21, 2014 and June 21, 2014, and there no significantly different findings reported between both MRI's. Additionally, there are no significant subjective or objective changes documented since the MRI's were performed. Finally, it is unclear how an MRI will change the patient's current treatment plan. As such, the currently requested left shoulder MRI is not medically necessary.