

Case Number:	CM14-0026517		
Date Assigned:	06/13/2014	Date of Injury:	11/27/2013
Decision Date:	07/16/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/03/2014

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 Medicine and is licensed to practice in Texas. 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 62 year old male who reported an injury to his left shoulder and both hips. The clinical note dated 12/17/13 indicates the injured worker complaining of left shoulder and bilateral hip pain. The injured worker stated the initial injury occurred secondary to prolonged walking and driving. The injured worker stated that he continually walks on uneven ground secondary to his job requirements. There is an indication the injured worker has previously undergone bilateral hip replacements. The left hip was replaced in 1995 and the right was completed in 1996. A revision of the right hip was also completed in 2012. The injured worker continued with complaints of severe levels of pain in both hips. The MRI of the left shoulder dated 01/17/14 revealed joint effusion with synovitis and sub corticoid bursitis. A paralabral cyst was also identified. The clinical note dated 02/24/14 indicates the injured worker complaining of upper extremity pain. The note indicates the injured worker utilizing Norco for ongoing pain relief. The note does indicate the injured worker having a past surgical history to include a C5 through C7 fusion in 2005. There is an indication that the injured worker has had no significant physical therapy or chiropractic treatments since 2005. The MRI of the cervical spine dated 03/03/14 revealed degenerative findings with retrolisthesis at C3-4 and C4-5. Postoperative changes were identified at C5-6 and C6-7. The utilization review dated 02/24/14 resulted in a non-certification for the requested extracorporeal shockwave therapy at the shoulder and electrodiagnostic studies of the lower extremities as the injured worker was identified as having radiculopathy determined by clinical exam. Additionally, the extracorporeal shockwave therapy resulted in a denial as no information had been submitted confirming the injured worker's calcifying tendonitis at the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 ESWT SESSIONS TO THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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, Extracorporeal shock wave therapy (ESWT).

Decision rationale: The documentation indicates the injured worker complaining of left shoulder pain. Extracorporeal shockwave therapy is indicated when there are findings consistent with calcifying tendonitis at the shoulder. No information was submitted confirming the injured worker's findings of calcific tendonitis. Given this, the request is not indicated as medically necessary.

EMG OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: Electrodiagnostic studies would be indicated provided findings are consistent with radiculopathy in the upper extremities. No information was submitted regarding the injured worker's significant clinical findings consistent with radiculopathy. No reflex, strength, or sensation deficits were identified. Given these findings, the request is not indicated as medically necessary.

NCS OF THE BILATERAL LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS).

Decision rationale: Electrodiagnostic studies would be indicated provided findings are consistent with radiculopathy in the upper extremities. No information was submitted regarding the injured worker's significant clinical findings consistent with radiculopathy. No reflex, strength, or sensation deficits were identified. Given these findings, the request is not indicated as medically necessary.