

Case Number:	CM14-0039918		
Date Assigned:	07/07/2014	Date of Injury:	01/23/2013
Decision Date:	08/06/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	04/04/2014

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 Therapy and Rehabilitation has a subspecialty in Interventional Spine 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 a 61-year-old female with date of injury of 01/23/2013. The listed diagnoses per [REDACTED], dated 02/05/2014, are: 1. Facial contusion with chronic pain. 2. Right hip chronic pain. 3. Rule out trochanteric bursitis. According to this report, the patient is receiving physical therapy which is helping with her right hip. She still reports some numbness and tingling, but it has improved since her last visit. The objective findings show there is a well-healed scar on the right eyebrow, and there is decreased sensation on the right side of the face as compared to the left. The patient is walking using a single-point cane. The hip is well muscled with no deformity. The skin is unremarkable. There are no obvious masses or muscle atrophy, and no surgical or traumatic scars or burns visible to the right hip. Palpation of the right trochanter reveals tenderness. FABERE's maneuver is positive on the right side. Range of motion has definitely improved in abduction, internal and external rotation, as well as extension. The utilization review denied the request on 03/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shock wave therapy: 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) Low Back Section/ Knee/ Leg Section, Shockwave Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG on Shock wave therapy for Lumbar spine.

Decision rationale: This patient presents with right hip and facial pain. The treater is requesting shockwave therapy. The MTUS and ACOEM Guidelines do not address this request specific to the hip pain; however, shockwave therapy is discussed under the lumbar spine and other chapter guidelines in the Official Disability Guidelines, (ODG). ODG does not support shockwave therapy for the lumbar spine. It is supported for certain conditions of the elbow, shoulder and heel. There is no guidelines support for the use of shockwave for the patient's hip and as such, the request is not medically necessary.