

Case Number:	CM14-0191850		
Date Assigned:	02/12/2015	Date of Injury:	05/05/2009
Decision Date:	03/31/2015	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/17/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Massachusetts

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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(IW) is a 60 year old female who sustained an industrial injury on 05/05/2009. She has reported pain in the neck, upper back and right shoulder. Diagnoses include cervical spine disc rupture, thoracic spine disc bulges, failed right shoulder surgery, left shoulder strain, and other problems unrelated to current evaluation. Treatment to date includes right shoulder surgery extracorporeal shockwave procedures, physical therapy, acupuncture to the right shoulder and planned revision of right shoulder surgery. Medical records of 08/27/2014 note the IW had a slip and fall on 11/1/12 in which she fell and lost consciousness. She sustained injury in the right shoulder, right hand, right knee, pelvis and low back. Right shoulder pain has increased and right shoulder is worse with decreased range of motion at that time. A progress note from the treating provider dated 10/01/2014 indicates the IW has pain in the right shoulder with diminished light touch sensation in the right thumb tip; right long fingertip and right small fingertip. Hand written note from the provider states that "right shoulder pain is getting worse and range of motion is less since the injury". On 10/23/2014 Utilization Review non-certified a request for Pain Medicine follow-up, noting the there is no clinical data presented to suggest the need for pain management consultation. The MTUS, ACOEM Guidelines were cited. On 10/23/2014 Utilization Review non-certified a request for Shockwave Therapy 1 x 3 - left shoulder noting the records fail to document plain radiography findings or any imaging study establishing a diagnoses of calcific rotator cuff tendonitis. The MTUS, ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave Therapy 1 x 3 - left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: According to ACOEM OMPG, regarding Shockwave Therapy: "Quality studies are available on extracorporeal shockwave therapy in acute, subacute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a recommendation against using extracorporeal shockwave therapy [Evidence (A), Strongly Recommended Against]." Guidelines support Shockwave Therapy in treatment of chronic calcific rotator cuff tendinitis of the shoulder which has failed conservative treatment, however there is no clear evidence in the provided records that indicate that this is the patient's condition. Consequently Shockwave Therapy is not supported by the records and clinical guidelines.

Pain Medicine follow-up: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 6, pg 112-114.

Decision rationale: The peer reviewer states that there is no clinical data presented to suggest the need for pain management consultation and therefore based on insufficient clinical information the medical necessity cannot be determined at this time. The peer reviewer however does not mention what clinical information is lacking and if any attempts were made to acquire the necessary clinical information. ACOEM guidelines support pain referral when conservative treatment has not been effective, there is no planned surgical intervention and pain symptoms are worsening. ACOEM OMPG Chapter 6 states: "Research suggests that multidisciplinary care is beneficial for most persons with chronic pain, and likely should be considered the treatment of choice for persons who are at risk for, or who have, chronic pain and disability"... "physicians should consider referral for further evaluation and perhaps cooperative treatment if: 1) specific clinical findings suggest undetected clinical pathology. 2) appropriate active physical therapy does not appear to be improving function as expected. 3) the patient experiences increased pain, or at the very least, pain does not decrease come over time" From my review of the records the treating provider, an orthopedist clearly describes that the IW has worsening pain symptoms, worsening functional capacity and physical exam findings despite conservative treatment received to date. Additionally there is no discussion of surgical intervention so follow-up with a pain provider is a more appropriate option at this point in treatment than orthopedic consultation.

