

Case Number:	CM15-0008019		
Date Assigned:	01/26/2015	Date of Injury:	07/17/2007
Decision Date:	03/20/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/14/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 49 year old male who sustained an industrial injury on 7/17/07. The injured worker reported symptoms in the left wrist and back. The diagnoses included cervical spondylosis with myelopathy. Treatments to date have included physical therapy, knee ankle foot orthosis, oral pain medications, wrist brace, service dog, aqua therapy and status post epidural catheter insertion on 12/23/12. PR2 dated 11/12/14 noted the injured worker presents with "restricted" range of motion to the left shoulder and left hemiparesis. The treating physician is requesting Shockwave therapy 1 x 6 to the left shoulder, cervical spine, lumbar spine, left foot and leg and a Tempurpedic adjustable bed. On 12/22/14, Utilization Review non-certified a request for Shockwave therapy 1 x 6 to the left shoulder, cervical spine, lumbar spine, left foot and leg and a Tempurpedic adjustable bed. The MTUS, ACOEM Guidelines, (or ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy 1x6 to the Left Shoulder, Cervical Spine, Lumbar Spine, Left Foot and Leg: 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 shockwave therapy (ESWT)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter and Knee & Leg Chapter, Extracorporeal shock wave therapy (ESWT)

Decision rationale: The patient presents with left wrist and back symptoms. The current request is for Shockwave therapy 1x6 to the left shoulder, cervical spine, lumbar spine, left foot and leg. The treating physician requested a course of shock wave therapy to reduce his pain and improve the sensation in his left shoulder, neck, back, left leg and foot on 12/10/14 (29). The MTUS guidelines do not address shockwave therapy. The ODG guidelines state for shoulder: Recommended for calcifying tendinitis but not for other shoulder disorders. The ODG guidelines state for knee and leg: Under study for patellar tendinopathy and for long-bone hypertrophic nonunions. The ODG provides no guidance on shockwave therapy to the cervical and lumbar spine. In this case, the treating physician has diagnosed Cervical Spondylosis with Myelopathy, which is not supported by ODG for shockwave therapy. Based on the records available for review, there is no justification for shockwave therapy to the shoulder as the patient has not been diagnosed with calcific tendinitis and the left leg, cervical and lumbar spine is not supported by ODG. The current request is not medically necessary and the recommendation is for denial.

Tempurpedic adjustable bed: 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, Current Edition (Web)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back - Lumbar & Thoracic, Mattress selection

Decision rationale: The patient presents with left wrist and back symptoms. The current request is for Tempurpedic adjustable bed. The treating physician requests, the patient to be provided with a Tempurpedic adjustable bed decrease his pain on his left side when he sleeps. The adjustable bed will also allow him to get out of bed with less difficulty on 12/10/14 (29). The MTUS guidelines do not address adjustable bedding. The ODG guidelines state: There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure. In this case, the treating physician, based on records available for review, has not documented any pressure ulcers. The current request is not medically necessary and the recommendation is for denial.

