

Case Number:	CM15-0100516		
Date Assigned:	06/30/2015	Date of Injury:	10/12/2014
Decision Date:	08/24/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/26/2015

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

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 34 year old male who sustained an industrial injury on October 12, 2014. He has reported back pain and has been diagnosed with cervical spine sprain/strain and lumbago. Treatment has included therapy. Cervical spine range of motion was restricted. There was pain on the right shoulder. There was tenderness to palpation of the right upper trapezius. The treatment request included shockwave therapy to the right shoulder, shockwave therapy to the left shoulder, orthopedic consult, and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy for right shoulder qty: 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://odg-twc.com/index.html?odgtwc/shoulder>.

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, ESWT.

Decision rationale: The patient was injured on 10/12/14 and presents with lumbar spine pain. The request is for SHOCKWAVE THERAPY FOR THE RIGHT SHOULDER QTY: 12. The RFA is dated 05/04/15 and the patient is on modified work duty. Review of the reports provided does not indicate if the patient had any prior shockwave therapy to the right shoulder. MTUS Guidelines and ACOEM Guidelines do not discuss extracorporeal shockwave treatments. ODG Guidelines under ESWT under the shoulder chapter states, "recommended for calcifying tendonitis, but not for other disorders, for patients with calcifying tendonitis of the shoulder and homogenous deposits, quality evidence had found extracorporeal shockwave therapy equivalent or better than surgery, and it may be given priority because of its noninvasiveness." The right shoulder has decreased strength, tenderness, equivocal impingement tests, estimated atrophy due to bilateral involvement, decreased range of motion, and positive x-rays (05/15/15) showing a type II acromion. He is diagnosed with cervical radiculitis syndrome, right/left shoulder sprain/ rule out impingement, and lumbosacral sciatic syndrome. Treatment to date has included therapy. There is no indication of the patient having calcifying tendonitis, as indicated by ODG guidelines. Therefore, the request for shockwave therapy for the right shoulder is not in accordance with ODG guidelines and is not medically necessary.

Shockwave therapy for left shoulder qty: 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://odg-twc.com/index.html?odgtwc/shoulder>.

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, ESWT.

Decision rationale: The patient was injured on 10/12/14 and presents with lumbar spine pain. The request is for SHOCKWAVE THERAPY FOR THE LEFT SHOULDER QTY: 12. The RFA is dated 05/04/15 and the patient is on modified work duty. Review of the reports provided does not indicate if the patient had any prior shockwave therapy to the right shoulder. MTUS Guidelines and ACOEM Guidelines do not discuss extracorporeal shockwave treatments. ODG Guidelines under ESWT under the shoulder chapter states, "recommended for calcifying tendonitis, but not for other disorders, for patients with calcifying tendonitis of the shoulder and homogenous deposits, quality evidence had found extracorporeal shockwave therapy equivalent or better than surgery, and it may be given priority because of its noninvasiveness." The left shoulder has decreased strength, tenderness, equivocal impingement tests, estimated atrophy due to bilateral involvement, decreased range of motion, and positive x-rays (05/15/15) showing a type II acromion. He is diagnosed with cervical radiculitis syndrome, right/left shoulder sprain/ rule out impingement, and lumbosacral sciatic syndrome. Treatment to date has included therapy. There is no indication of the patient having calcifying tendonitis, as indicated by ODG guidelines. Therefore, the request for shockwave therapy for the left shoulder is not in accordance with ODG guidelines and is not medically necessary.

One ortho consult: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, Chapter 7 Independent Medical Examinations and Consultation, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7 page 127.

Decision rationale: The patient was injured on 10/12/14 and presents with lumbar spine pain. The request is for ONE ORTHO CONSULT. The utilization review denial rationale is that there is no documentation of red flags or of failure of conservative care to clarify rationale. The RFA is dated 05/04/15 and the patient is on modified work duty. ACOEM Practice Guidelines, 2nd edition (2004), page 127, has the following: "Occasional health practitioner may refer to other specialists if the diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." MTUS/ACOEM, Chapter 12, Low Back Complaints, page 305, under the topic 'Surgical Considerations' states surgical consultation is indicated for patients who have: "Failure of conservative treatment to resolve disabling radicular symptoms." The left shoulder has decreased strength, tenderness, equivocal impingement tests, estimated atrophy due to bilateral involvement, decreased range of motion, and positive x-rays (05/15/15) showing a type II acromion. He is diagnosed with cervical radiculitis syndrome, right/left shoulder sprain/ rule out impingement, and lumbosacral sciatic syndrome. Treatment to date has included therapy. Given the patient's chronic pain, a second opinion appears medically reasonable. Therefore, the requested ortho consult is medically necessary.

One acupuncture: Overturned

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines Page(s): 13.

Decision rationale: The patient was injured on 10/12/14 and presents with lumbar spine pain. The request is for ONE ORTHO CONSULT. The utilization review denial rationale is that it is unclear for which body part the request is intended and no documentation that pain meds have been decreased or not tolerated or that therapy is intended to be used as adjunct to other therapies. The RFA is dated 05/04/15 and the patient is on modified work duty. Review of the reports provided does not indicate if the patient has had any prior acupuncture sessions. For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. The left shoulder has decreased strength, tenderness, and equivocal impingement tests, estimated

atrophy due to bilateral involvement, decreased range of motion, and positive x-rays (05/15/15) showing a type II acromion. He is diagnosed with cervical radiculitis syndrome, right/left shoulder sprain/ rule out impingement, and lumbosacral sciatic syndrome. Treatment to date has included therapy. The reason for the request is not provided. In this case, there is no indication that the patient has had any prior acupuncture sessions. The requested 6 sessions of acupuncture appears medically reasonable and is within MTUS guidelines. The request is medically necessary.