

Case Number:	CM15-0143078		
Date Assigned:	08/03/2015	Date of Injury:	06/12/2009
Decision Date:	09/02/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/23/2015

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, Pain Management

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 58 year old female who sustained an industrial injury on 06/12/2009. The injured worker was diagnosed with chronic right shoulder impingement, left shoulder rotator cuff tear, supraspinatus with acromioclavicular osteoarthropathy, protrusion C5-6, myofascial pain, L2-L3 and L3-L4 radiculopathy and calcific tendinitis right shoulder. The injured worker is status post right shoulder rotator cuff repair with partial claviclectomy in September 2014. Treatment to date has included diagnostic testing, surgery, physical therapy (18 sessions completed), transcutaneous electrical nerve stimulation (TEN's) unit, home exercise program and medications. According to the primary treating physician's progress report on June 15, 2015, the injured worker continues to experience right shoulder pain with decreased range of motion rated at 8 out of 10 on the pain scale. The injured worker also reports neck, left shoulder and lower back pain rated at 5 out of 10 on the pain scale. Examination demonstrated tenderness to the right shoulder with swelling and atrophy of the right deltoid musculature noted. Motor strength was documented at 4 out of 5. Range of motion was noted as flexion at 100 degrees, abduction at 90 degrees, external and internal rotation at 50 degrees each. The left shoulder demonstrated diffuse tenderness with range of motion as flexion at 130 degrees, abduction at 120 degrees, external rotation at 70 degrees and internal rotation at 80 degrees. Tenderness was documented at the cervical and lumbar spine with limited range of motion. Current medication listed was Cyclobenzaprine. No other medications were documented. Treatment plan consists of additional physical therapy and the current request for chiropractic therapy to the cervical and lumbar spine and extracorporeal shockwave therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shock Wave Therapy to Treat Refractory Calcifying Tendinitis for the Right Shoulder x 3 Sessions: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Extracorporeal Shock Wave Therapy (ESWT).

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 Shockwave Therapy (ESWT).

Decision rationale: Regarding the request for extracorporeal shockwave therapy, Occupational Medicine Practice Guidelines support the use of extracorporeal shock wave therapy for calcified tendinitis of the shoulder. ODG further clarifies that extracorporeal shockwave therapy is recommended for calcified tendinitis of the shoulder but not for other shouldered disorders. Within the documentation available for review, there is identification of a diagnosis of calcified tendinitis. As such, the currently requested extracorporeal shock wave therapy is medically necessary.

Chiropractic Treatment 3 x 4 for the Cervical and Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic section Page(s): 58-60.

Decision rationale: Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. However, these guidelines specify for an initial trial of up to 6 visits. Only with evidence of objective functional improvement, can further session be supported. It is unclear whether the patient and undergone previous chiropractic care and how many sessions she has attended. Furthermore, there is no documentation regarding what functional gain were achieved as a result of previous chiropractic sessions. Therefore this request is not medically necessary.