

<b>Case Number:</b>	CM15-0206337		
<b>Date Assigned:</b>	10/26/2015	<b>Date of Injury:</b>	08/27/2011
<b>Decision Date:</b>	12/07/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 is a 50 year old male who sustained an industrial injury on 8-27-11. He is not working. The medical records indicate that the injured worker was being treated for cervical spondylosis; protrusion C2-C7; acromioclavicular osteoarthopathy left shoulder pain; superior labrum anterior on posterior lesion left shoulder; tear supraspinatus left shoulder and partial tear infraspinatus; status post left shoulder arthroscopy- rotator cuff repair; tendinosis infraspinatus and supraspinatus, right shoulder; bilateral carpal tunnel syndrome; bilateral trigger thumbs; myofascial low back pain; lumbar radiculopathy; cervical pain; thoracic pain; calcific tendinitis-tendinopathy left shoulder. He currently (9-15-15) complains of cervical pain left greater than right upper extremity symptoms with a pain level of 7 out of 10; headache; left shoulder pain refractory to physical therapy, injection, home exercise and activity modification (9 out of 10); right shoulder pain (6 out of 10); thoracic pain (5 out of 10); low back pain with lower extremity symptoms (6 out of 10); right wrist-hand pain (5 out of 10); left wrist-hand pain (5 out of 10). On physical exam there was tenderness of the cervical spine, decreased range of motion, diminished sensation left greater than right C5-C7 dermatomal distribution median and ulnar distributions; diffuse tenderness of the thoracic spine with limited motion; tenderness and spasms of the lumbar spine with decreased range of motion, diminished sensation left greater than right L4, L5, S1 dermatomal distribution, positive straight leg raise bilaterally; left and right shoulder tenderness, positive impingement signs, decreased range of motion; positive Tinel's and Phalen's bilateral wrists. Diagnostics include lower extremity nerve conduction (3-23-15) abnormal with evidence suggestive of a right tibial motor nerve neuropathy; lower extremity

electromyography (3-26-15) revealed a normal study. Treatments included the above mentioned and medication: hydrocodone, cyclobenzaprine, naproxen, pantoprazole, Ambien; acupuncture. In the progress note dated 8-25-15 the treating provider's plan of care included requests for shockwave therapy to the left shoulder times 3; MRI arthrogram of the left shoulder; DNA genetic testing to select proper medications suitable for this injured worker. The specific request for authorization was not present. On 9-29-15 Utilization Review non-certified the requests for shockwave therapy to the left shoulder times 3; DNA genetic testing; MRI arthrogram of the left shoulder.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Shockwave therapy left shoulder, 3 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), Extracorporeal shockwave 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 section, Extracorporeal shockwave therapy and Other Medical Treatment Guidelines [http://www.aetna.com/cpb/medical/data/600\\_699/0649.html](http://www.aetna.com/cpb/medical/data/600_699/0649.html).

**Decision rationale:** Pursuant to the ACOEM, shockwave therapy to the left shoulder three sessions is not medically necessary. Aetna considers extracorporeal shock-wave therapy (ESWT) medically necessary for calcific tendinopathy of the shoulder of at least 6 months duration with calcium deposit of 1 cm or greater, and who have failed to respond to appropriate conservative therapies (e.g., rest, ice application, and medications). Aetna considers extracorporeal shock-wave therapy (ESWT), extracorporeal pulse activation therapy (EPAT) (also known as extracorporeal acoustic wave therapy) experimental and investigational for the following indications (not an all-inclusive list) because there is insufficient evidence of effectiveness of ESWT for these indications in the medical literature: Achilles tendonitis (tendinopathy); Delayed unions; Erectile dysfunction; Lateral epicondylitis (tennis elbow); Low back pain; Medial epicondylitis ( golfers elbow); Non-unions of fractures; Osteonecrosis of the femoral head; Patellar tendinopathy; Peyronie's disease; Rotator cuff tendonitis (shoulder pain); Stress fractures; Wound healing (including burn wounds); Other musculoskeletal indications (e.g., calcaneal spur, Hammer toe, tenosynovitis of the foot or ankle, and tibialis tendinitis). In this case, the injured worker's working diagnoses are cervical spondylosis; acromioclavicular osteoarthropathy; SLAP lesion left shoulder; tear supraspinatus left shoulder and partial tear infraspinatus ; status post left shoulder arthroscopy; acromioclavicular osteoarthropathy right shoulder; tendinosis infraspinatus and supraspinatus right shoulder; bilateral carpal tunnel syndrome; bilateral trigger thumbs; myofascial low back pain; lumbar radiculopathy; thoracic pain; and calcific tendinitis/tendinopathy left shoulder. Date of injury is August 27, 2011. Request for authorization is September 22, 2015. According to an August 25, 2015 progress note, subjective complaints include cervical pain left with an right with the pain score of 7/10. Left shoulder pain is present with pain score of 9/10. Left shoulder is refractory to physical therapy and home exercises. Additional complaints include right shoulder pain, thoracic and

lumbar pain. The documentation shows an MRI was performed July 18, 2014 that show residual lateral down sloping acromion, partial articular tear of the supraspinatus. There are no calcific lesions documented. The reviewing provider states the MRI showed artifact. Objectively, there is decreased range of motion in the shoulders. The treating provider does not specify left versus right shoulder on the objective examination. There is tenderness present. There is no objective evidence of calcific tendinitis on radiographs of magnetic resonance imaging. There is no clinical indication or rationale for shockwave therapy to the left shoulder. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no objective evidence of calcific tendinitis and guideline non recommendations based on insufficient evidence of effectiveness, shockwave therapy to the left shoulder three sessions is not medically necessary.

**DNA Genetic testing:** 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), Pain Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Cytokine DNA testing.

**Decision rationale:** Pursuant to the Official Disability Guidelines, DNA genetic testing is not medically necessary. Cytokine DNA testing is not recommended. There is no current evidence to support the use of cytokine DNA testing for the diagnosis of pain, including chronic pain. In this case, the injured worker's working diagnoses are cervical spondylosis; acromioclavicular osteoarthropathy; SLAP lesion left shoulder; tear supraspinatus left shoulder and partial tear infraspinatus; status post left shoulder arthroscopy; acromioclavicular osteoarthropathy right shoulder; tendinosis infraspinatus and supraspinatus right shoulder; bilateral carpal tunnel syndrome; bilateral trigger thumbs; myofascial low back pain; lumbar radiculopathy; thoracic pain; and calcific tendinitis/tendinopathy left shoulder. Date of injury is August 27, 2011. Request for authorization is September 22, 2015. According to an August 25, 2015 progress note, subjective complaints include cervical pain left with an right with the pain score of 7/10. Left shoulder pain is present with pain score of 9/10. Left shoulder is refractory to physical therapy and home exercises. Additional complaints include right shoulder pain, thoracic and lumbar pain. The documentation shows an MRI was performed July 18, 2014 that show residual lateral down sloping acromion, partial articular tear of the supraspinatus. There are no calcific lesions documented. The reviewing provider states the MRI showed artifact. Objectively, there is decreased range of motion in the shoulders. The treating provider does not specify left versus right shoulder on the objective examination. There is tenderness present. There is no objective evidence of calcific tendinitis on radiographs of magnetic resonance imaging. Cytokine DNA testing is not recommended. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines and guideline non-recommendations for DNA testing, DNA genetic testing is not medically necessary.

**MRI arthrogram left shoulder:** 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), Shoulder (Acute and Chronic), MR arthrogram.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Arthrography.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI arthrogram left shoulder is not medically necessary. MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. MRI may be preferred because of better demonstration of soft tissue anatomy. Subtle tears that are full thickness are best image by arthrography. Larger tears and partial thickness tears are better demonstrated by MRI. In this case, the injured worker's working diagnoses are cervical spondylosis; acromioclavicular osteoarthropathy; SLAP lesion left shoulder; tear supraspinatus left shoulder and partial tear infraspinatus; status post left shoulder arthroscopy; acromioclavicular osteoarthropathy right shoulder; tendinosis infraspinatus and supraspinatus right shoulder; bilateral carpal tunnel syndrome; bilateral trigger thumbs; myofascial low back pain; lumbar radiculopathy; thoracic pain; and calcific tendinitis/tendinopathy left shoulder. Date of injury is August 27, 2011. Request for authorization is September 22, 2015. According to an August 25, 2015 progress note, subjective complaints include cervical pain left with an right with the pain score of 7/10. Left shoulder pain is present with pain score of 9/10. Left shoulder is refractory to physical therapy and home exercises. Additional complaints include right shoulder pain, thoracic and lumbar pain. The documentation shows an MRI was performed July 18, 2014 that show residual lateral down sloping acromion, partial articular tear of the supraspinatus. There are no calcific lesions documented. The reviewing provider states the MRI showed artifact. Objectively, there is decreased range of motion in the shoulders. The treating provider does not specify left versus right shoulder on the objective examination. There is tenderness present. There is no objective evidence of calcific tendinitis on radiographs of magnetic resonance imaging. MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. MRI may be preferred because of better demonstration of soft tissue anatomy. The treating provider does not indicate whether significant restricted range of motion or recurrent rotator cuff tears will require arthroscopic surgery. Additionally, there is no treating provider discussion of specific treatment that would be made based on the MR arthrogram. Based on the clinical information in medical record, peer-reviewed evidence-based guidelines, documentation showing an MRI was performed July 18, 2014 that showed residual lateral down sloping acromion, partial articular tear of the supraspinatus, and no treating provider discussion of specific treatment that would be made based on the MR arthrogram, MRI arthrogram left shoulder is not medically necessary.