

<b>Case Number:</b>	CM15-0060022		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	07/08/2009
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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 was a 56 year old female, who sustained an industrial injury, July 8, 2009. The injured worker previously received the following treatments cervical spine MRI, EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the upper extremities, bilateral shoulder x-rays, Motrin, Tramadol, Prilosec, Norco, left shoulder MRI, right shoulder MRI, physical therapy, anti-inflammatory medication, subacromial cortisone injection and bilateral shoulder surgeries in 2011. The injured worker was diagnosed with persistent symptomatic impingement syndrome, distal clavicle arthrosis of both shoulders and possible completed rotator cuff tear of the left shoulder. According to progress note of March 9, 2015, the injured workers chief complaint was bilateral shoulder pain, left greater than the right. The injured worker reported ongoing pain, swelling, and catching in the right shoulder. The injured worker reported pain during the day and at night. The injured worker has failed conservative treatment. The physical exam noted decreased range of motion in the bilateral shoulders, left worse than the right. The treatment plan included physical therapy and extracorporeal shock wave therapy for the left shoulder. The progress report dated March 9, 2015 indicates that the patient was treated with physical therapy, anti-inflammatory medication, and injections after surgery in 2011. A follow-up MRI identified partial and complete rotator cuff tears. Physical examination revealed restricted range of motion and positive rotator cuff maneuvers in both shoulders. The patient also has reduced strength in the shoulders bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Extracorporeal Shock Wave Therapy, Maximum of 3 Sessions Over 3 Weeks, Left Shoulder Qty 3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. 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 no identification of a diagnosis of calcified tendinitis. As such, the currently requested extracorporeal shock wave therapy is not medically necessary.

**Physical Therapy 2 Times A Week for 3 Weeks Bilateral Shoulders Qty 6: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, it appears the patient has previously undergone shoulder surgery with postoperative physical therapy. However, new MRIs identify new diagnoses for which additional therapy does not appear to have been provided. The patient has significant functional deficits as well as physical examination findings consistent with the diagnoses listed. Therefore, an initial trial of 6-visits to address these new issues identified by MRI is a reasonable next step in conservative treatment. Therefore, the currently requested physical therapy is medically necessary.