MAXIMUS Federal Services

Case Number:	CM13-0057435		
Date Assigned:	12/30/2013	Date of Injury:	10/04/2011
Decision Date:	04/07/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient has a date of birth [redacted] and a date of injury 10/4/11. The right shoulder and right wrist are accepted body parts by the carrier. There are requests for electric shockwave treatment to the right shoulder, right elbow, and right wrist. The diagnoses have included a chronic sprain/strain of cervicothoracic spine and associated musculoligamentous structures with 1-2 mm disc protrusion at C5-C6 with advanced left facet arthrosis; bilateral tennis elbow and bilateral carpal tunnel syndrome; chronic tendinitis and impingement of both shoulders, right greater than left with abnormal MRI; bilateral tennis elbow and bilateral carpal tunnel syndrome; bilateral wrist strains, particularly in the right with scapholunate disassociation in the right; chronic sprain/strain of lumbosacral spine and associated musculoligamentous structures with multilevel lumbar disc disease characterized by 4 mm disc protrusions at Ll-L2,L2-L3, 3- 4 mm disc protrusion at L4-L5 with severe right foraminal stenosis and 2 mm diffused bulge at L5-SI per MRI of April 18, 2012; internal derangement per MRI, status post surgery, left knee, still symptomatic; pre-patellar bursitis right knee; status post knee injury dated 9/25/12. A 4/19/13 MRI of the left shoulder revealed a small distal supraspinatus tendon tear. There is a type 2 acromion with a small spur in the region of attachment to the coracoacromial ligament. There is moderate-severe degeneration of the acromioclavicular joint and inferior peri-articular spur formation and capsular hypertrophy. There are increased fluid subacromial-sub deltoid bursae consistent with bursitis. There is slight degenerative arthritis of the glenohumeral joint. There is Final Determination Letter for IMR Case Number [redacted] documentation that patient has had electric shockwave treatment on 01/10/13 to the bilateral wrists. An 11/20/13 re-evaluation by the primary treating physician states that patient remains symptomatic. He is sore in the neck, shoulders, backs and knees. A physical exam reveals: Exam of the back: flexion 30,

extension 33. He tender in the par cervical muscles. Exam of the back: flexion 40, extension 35. He is tender at the L1 through S1 area.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTRIC SHOCKWAVE TREATMENT-RIGHT 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: Electric shockwave treatment to the right shoulder is not medically necessary per the MTUS guidelines. The ACOEM guidelines state that there is some medium quality evidence for high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. The ODG recommends extracorporeal shock wave therapy (ESWT) for calcifying tendinitis but not for other shoulder disorders. The documentation submitted reveals no evidence of calcifying tendonitis in the right shoulder. The request for electric shockwave treatment to the right shoulder is therefore not medically necessary.

ELECTRIC SHOCKWAVE TREATMENT-RIGHT ELBOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow, Extracorporeal shockwave therapy (ESWT).

Decision rationale: Electric shockwave treatment-right elbow is not medically necessary per the MTUS guidelines. The ACOEM states that since quality studies are not available on extracorporeal shockwave therapy in acute, sub acute, and chronic lateral epicondylalgia patients and benefits have not been shown us, there is a recommendation against using extracorporeal shockwave therapy. The documentation submitted states that the patient has diagnoses of bilateral tennis elbow. This is a contraindication for ESWT treatment per the ODG criteria. Additionally the patient has Final Determination Letter for IMR Case Number [redacted] evidence of arthrosis on cervical imaging which is another contraindication. These findings, in addition to a lack of quality studies for electric shockwave to the elbow are reasons why electric shockwave treatment to the right elbow is not medically necessary.

ELECTRIC SHOCKWAVE TREATMENT-RIGHT WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7-8. Decision based on Non-MTUS Citation Washington State Department of Labor and Industries, Office of the Medical Director.

Decision rationale: Electric shockwave treatment-right wrist is not medically necessary per the MTUS guidelines. The MTUS or ODG guidelines were reviewed and do not specifically address electric shockwave treatment for the wrists. The MTUS does state, however, that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. Additionally, an assessment of extracorporeal shock wave therapy conducted by the Washington State Department of Labor and Industries (2003) concluded that "the evidence establishing the effectiveness [of ESWT] for musculoskeletal conditions remains inconclusive. The documentation submitted reveals that the patient has had electric shockwave treatment in the past to the wrists. The documentation submitted does not reveal that this has led to a significant functional improvement or a sustained decrease in pain for the patient. The request for electric shockwave treatment to the right wrist is therefore not medically necessary.