

Case Number:	CM14-0111296		
Date Assigned:	08/01/2014	Date of Injury:	03/27/2001
Decision Date:	06/15/2015	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/17/2014

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: Pennsylvania
 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 60 year old female who sustained a work related injury March 27, 2001. While transferring a patient from bed to a wheelchair, the patient slipped and in an attempt to break the patient's fall, the injured worker pulled the patient upwards and felt immediate sharp pain in her lower back, more on the right side, radiating to her right leg. Diagnoses included left shoulder sprain/strain with adhesive capsulitis, RCT (rotator cuff tear), and frozen shoulder, lumbar spine sprain/strain with disc bulges and herniated nucleus pulposus of L4-5, and left knee unspecified internal derangement. Treatment has included epidural injections, steroid injection to the left shoulder, acupuncture, chiropractic treatment, physical therapy, facet block, transcutaneous electrical nerve stimulation (TENS) unit, and medications. MRI of the left shoulder on 7/7/11 showed tendinosis with partial tear of the rotator cuff, and mild impingement syndrome. X-rays of the left shoulder on 1/22/14 showed no acute fracture or osseous abnormality. An initial orthopedic report from the primary treating physician on 1/22/14 noted low back and left shoulder pain. Examination showed tenderness along the left acromioclavicular joint, left biceps tendon groove, left supraspinatus deltoid complex and left rotator cuff; glenohumeral labral testing for instability was unable to be tested due to frozen shoulder. Examination of the lumbar spine showed decreased range of motion, normal sensation and motor power, tenderness about the L5-S1 spinous processes, and positive straight leg raising on the right. Examination of the knees showed no swelling, effusion, or synovitis, medial joint line tenderness on the right and lateral joint line tenderness bilaterally, positive McMurray's test at the lateral joint line and negative on the left, and negative Apley's, anterior and posterior drawer

tests, and Lachman's tests bilaterally. Medial and lateral collateral ligaments were bilaterally intact to varus and valgus stress. Examination in April 2014 was noted as unchanged. According to a primary treating physician's progress report, dated June 10, 2014, the injured worker presented with constant left shoulder pain, 5/10 in severity, described as tightness which radiates up to the neck and down to the elbow. The pain increases with use and elevation and the left hand goes numb at night. There are complaints of constant lumbar spine pain, 8/10 in severity, described as dull and pulsating. The pain occasionally radiates to the right great toe. She stated that lumbar epidural injections helped for a year and chiropractic treatment helped momentarily. There is also increased pain and giving way of the left knee. Examination showed left shoulder tenderness with positive Neer's and Hawkin's testing, tenderness of the thoracic, lumbar, and sacral spine with spasm of the lumbar spine. Examination of the knee was not submitted. Treatment plan included request for a lumbar sacral brace, extracorporeal shockwave therapy, neoprene knee brace, and solar care heat system. Work status was noted as modified duty with no heavy work and no work above shoulder level. On 6/24/14, Utilization Review (UR) non-certified requests for the items currently under Independent Medical Review, citing the ACOEM and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Extracorporeal Shockwave Therapy for Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 224. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter: ESWT.

Decision rationale: The ACOEM shoulder chapter includes a reference regarding use of shock wave therapy for chronic calcifying tendinitis of the shoulder, but does not make specific recommendation regarding this modality. The ODG states that criteria for use of ESWT for the shoulder include pain from calcifying tendinitis of the shoulder that has remained despite six months of standard treatment, at least three conservative treatments have been performed prior to the use of ESWT, and lack of certain specific contraindications. This injured worker has diagnoses of left shoulder sprain/strain, adhesive capsulitis, rotator cuff tear, and frozen shoulder. There was no documentation of calcifying tendinitis of the left shoulder. MRI and plain x-rays of the left shoulder did not demonstrate calcifying tendinitis. Due to lack of specific indication, the request for 1 Extracorporeal Shockwave Therapy for Left Shoulder is not medically necessary.

1 LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 308.

Decision rationale: This injured worker has chronic low back pain. The treating physician has prescribed a LSO (lumbar-sacral orthosis) brace. The ACOEM Guidelines do not recommend lumbar binders, corsets, or support belts as treatment for low back pain, see page 308. On Page 9 of the Guidelines, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security." Due to guideline recommendations against the use of lumbar supports, the request for 1 LSO Brace is not medically necessary.

1 Solar Care FIR Heat System: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 48, 212, 299, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: heat therapy.

Decision rationale: This injured worker has chronic back and shoulder pain. Per the ACOEM low back chapter, at-home applications of heat or cold may be used for symptom control for low back complaints. Per the ODG, heat therapy is recommended as an option for treating low back pain. Both the MTUS and ODG recommend at-home local applications of cold packs in the first few days of acute complaint and thereafter applications of heat packs or cold packs. There is no recommendation for any specific device in order to accomplish this. There was lack of documentation to indicate the frequency of use of the device, and no endpoint to use was specified. In addition, there was no documentation as to why at-home application of hot packs would be insufficient. For these reasons, the request for 1 Solar Care FIR Heat System is not medically necessary.

1 Neoprene Knee Brace for the Left Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee chapter: knee brace.

Decision rationale: The ACOEM recommends use of a knee sleeve as an option for the treatment of patellofemoral syndrome. The ODG notes certain recommendations for prefabricated knee braces, including knee instability, ligament insufficiency/deficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental

osteoarthritis, and tibial plateau fracture. The ODG states that braces need to be used in conjunction with a rehabilitation program and are necessary only if the patient is going to be stressing the knee under load. This injured worker was noted to have unspecified internal derangement of the left knee. Examination in January 2014 did not show any evidence of left knee instability or ligament insufficiency. There was no history of knee surgery. No imaging studies of the knee were submitted. At the visit on 6/10/14, the injured worker reported pain and giving way of the left knee. No examination of the on that date was documented. Work status was noted as modified duty with no heavy work and no work above shoulder level. There was no documentation of a current rehabilitation program or need to stress the knee under load. None of the guideline criteria for use of a knee brace were present for this injured worker. Due to lack of specific indication, the request for 1 Neoprene Knee Brace for the Left Knee is not medically necessary.