

<b>Case Number:</b>	CM15-0122733		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	03/27/2007
<b>Decision Date:</b>	09/15/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency 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 49 year old female, who sustained an industrial injury on 3/27/07. The injured worker has complaints of burning, radicular neck pain and muscle spasms. The pain radiates into the bilateral upper extremities, associated with numbness and tingling. The complaints of burning right shoulder pain radiating down the arm to the fingers, associated with muscle spasms. The injured worker complains of burning right elbow pain and muscle spasms. The documentation noted cervical spine has tenderness to palpation at the suboccipital, scalene and sternocleid mastoid muscles. Cervical spine range of motion is decreased. Right shoulder examination reveals tenderness to palpation at the acromioclavicular (AC) joint and subacromial space. Right shoulder range of motion is decreased. Right elbow examination showed tenderness to palpation at the lateral and medial epicondyle. Bilateral wrist examination showed tenderness to palpation over the carpal tunnel. The diagnoses have included cervicalgia; radiculopathy, cervical region; cervical disc degeneration; right shoulder tendonitis; primary osteoarthritis, right shoulder and right shoulder rotator. Treatment to date has included bilateral carpal tunnel release with residual pain; medications; acupuncture; magnetic resonance imaging (MRI) right shoulder showed 2/11/15 acromion, flat, laterally down sloping, acromioclavicular joint osteoarthritis; magnetic resonance imaging (MRI) right elbow on 2/10/15 showed radial collateral ligament and lateral ulnar collateral ligament, sprain versus partial thickness tear; magnetic resonance imaging (MRI) of left wrist on 2/10/15 showed positive ulnar variance, relatively unchanged since the previous study, degenerative marginal osteophyte off the lateral margin of the distal radius and magnetic resonance imaging (MRI) of the cervical spine on 2/12/15 showed

straightening of the normal cervical lordosis with restriction of range of motion in flexion and extension views which may be positional or reflection an element of myospasm. The request was for physical therapy 3x6 for the cervical spine, right shoulder and lumbar spine; Shockwave therapy 3 treatment sessions for the right shoulder, bilateral wrists, right elbow; shockwave therapy 6 treatment sessions for the cervical spine and lumbar spine; platelet-rich plasma injection right shoulder and retrospective request for extracorporeal shockwave therapy to the cervical spine times one, date of service 05/11/15.

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

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

#### **Physical Therapy 3x6 for the cervical spine, right shoulder and lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering, Restoration of Function, page 114 and on the Non-MTUS Official Disability Guidelines (ODG), Neck & Upper Back, Shoulder, and Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the requested number of 18 visits surpasses the number of six recommended for clinical trial to determine functional improvement. In addition the requested number of visits also surpasses the maximum number of visits recommended. The request should not be authorized and is not medically necessary.

#### **Shockwave therapy 3 treatment sessions for the right shoulder, bilateral wrists, right elbow: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, criteria for the use of Extracorporeal Shock Wave Therapy (ESWT); Elbow Chapter, criteria for the use of 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: Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** Shock wave therapy is recommended for calcifying tendinitis but not for other shoulder disorders. Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT): 1) Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. 2) At least three conservative treatments have been performed prior to use of ESWT. These would include: a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone). 3) Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. 4) Maximum of 3 therapy sessions over 3 weeks. In this case the patient is not diagnosed with calcific tendinitis. ESWT is not medically necessary. The request should not be authorized.

**Shockwave therapy 6 treatment sessions for the cervical spine and lumbar spine:** 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), Low Back Chapter, Shockwave therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Thoracic and lumbar: shock wave therapy, Neck and Upper Back: Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** Shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating back and neck pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The request should not be authorized. The request is not medically necessary.

**PRP injection 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), Shoulder Chapter, platelet-rich plasma (PRP).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Platelet-rich plasma (PRP).

**Decision rationale:** Platelet-rich Plasma (PRP) is under study as a solo treatment. PRP augmentation is recommended as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. PRP looks promising, but it may not be ready for prime time as a

solo treatment. PRP has become popular among professional athletes because it promises to enhance performance, but there is no science behind it yet. In a blinded, prospective, randomized trial of PRP vs. placebo in patients undergoing surgery to repair a torn rotator cuff, there was no difference in pain relief or in function. The only thing that was significantly different was the time it took to do the repair; it was longer if you put PRP in the joint. There were also no differences in residual defects on MRI. In this case the patient does not have the diagnosis of massive rotator cuff tear. PRP is not indicated. The request should not be authorized. The request is not medically necessary.

**Retrospective request for extracorporeal shockwave therapy to the cervical spine x1, DOS: 05/11/15: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation "Extracorporeal Shock Wave Therapy for Orthopedic Conditions".

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** Shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating back and neck pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The request should not be authorized. The request is not medically necessary.