

Case Number:	CM15-0129398		
Date Assigned:	07/16/2015	Date of Injury:	12/08/2007
Decision Date:	08/12/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/03/2015

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: Massachusetts

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 is a 58 year old female who sustained an industrial injury on 12/8/07 from a slip and fall injuring her right shoulder. She currently complains of low back pain with left lower extremity symptoms (8/10); right shoulder pain (5/10); left shoulder pain (3/10); right and left wrist pain (5/10). On physical exam there was tenderness of the lumbar spine with decreased range of motion, positive straight leg raise, diminished sensation left L5 and S1 dermatomal distribution; spasm lumbosacral musculature. Per physical therapy progress note dated 3/5/15 the injured worker had decreased pain and increased strength since starting physical therapy but pain continues to prevent her from performing overhead activities of daily living, lifting using right upper extremity and continued numbness with prolonged writing. Medications were hydrocodone, ibuprofen, cyclobenzaprine, Colace. Diagnoses include failed lumbar surgery (2005); right shoulder arthroscopic subacromial decompression (11/2013); status post lumbar decompression L3-4 (6/16/05); neural encroachment L3-4 and L4-5 with radiculopathy, L5-S1; spondylolisthesis L2-3 and L3-4; bilateral wrist/ hand pain; bipolar I; anxiety disorder. Treatments to date included transcutaneous electrical nerve stimulator unit with relief of pain and decrease in pain medication; LSO brace offered improved tolerance to standing and walking; physical therapy; cognitive behavioral therapy. Diagnostics include electromyography/ nerve conduction study of upper extremities indicating C6-7 and the left and C7 on the right; MRI of the lumbar spine (8/11/12) showing degenerative disc disease, anterolisthesis, retrolisthesis. In the progress note dated 6/4/15 the treating provider's plan of care includes requests for physical therapy to the right shoulder 3three times per week for four weeks with emphasis on

strengthening and work hardening of right shoulder as she is relatively deconditioned; physical therapy lumbar spine three times per week for four weeks; extracorporeal shock wave therapy to treat recalcifying tendinitis right shoulder, three sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shock Wave Therapy, Right Shoulder, Qty 3: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - 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 (Acute & Chronic), Extracorporeal shock wave therapy (ESWT).

Decision rationale: The claimant sustained a work-related injury in December 2007 and continues to be treated for bilateral shoulder, left wrist, and low back pain. She underwent a lumbar decompression and fusion in 2005. A right shoulder subacromial decompression was done in November 2013. She has anxiety and major depressive disorder. She had physical therapy in 2013 and another course of therapy was started in February 2015. When seen, there was decreased right shoulder range of motion with positive impingement testing. There was right deltoid swelling. There was decreased lumbar spine range of motion. There was right knee tenderness with positive McMurray testing and joint line tenderness. There was decreased left lower extremity sensation with positive left straight leg raising. Diagnoses included right shoulder calcific tendinitis. Authorization for physical therapy and shockwave treatments was requested. Extracorporeal shock wave therapy (ESWT) can be recommended for calcifying tendinitis of the shoulder with up to 3 treatment sessions over three weeks. In this case, the claimant's provider documents a diagnosis of calcific tendinitis and the number of treatments being requested is within the guideline recommendation. The request is medically necessary.

Physical Therapy, Right Shoulder, 12 sessions (frequency unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work-related injury in December 2007 and continues to be treated for bilateral shoulder, left wrist, and low back pain. She underwent a lumbar decompression and fusion in 2005. A right shoulder subacromial decompression was done in November 2013. She has anxiety and major depressive disorder. She had physical therapy in 2013 and another course of therapy was started in February 2015. When seen, there

was decreased right shoulder range of motion with positive impingement testing. There was right deltoid swelling. There was decreased lumbar spine range of motion. There was right knee tenderness with positive McMurray testing and joint line tenderness. There was decreased left lower extremity sensation with positive left straight leg raising. Diagnoses included right shoulder calcific tendinitis. Authorization for physical therapy and shockwave treatments was requested. The claimant is being treated for chronic pain with no new injury and has recently had physical therapy. Patients are expected to continue active therapies and compliance with an independent exercise program would be expected without a need for ongoing skilled physical therapy oversight. An independent exercise program can be performed as often as needed/appropriate rather than during scheduled therapy visits. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. Skilled therapy in excess of that necessary could promote dependence on therapy provided treatments. The request is not medically necessary.

Physical Therapy, Lumbar Spine, 12 sessions (frequency unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work-related injury in December 2007 and continues to be treated for bilateral shoulder, left wrist, and low back pain. She underwent a lumbar decompression and fusion in 2005. A right shoulder subacromial decompression was done in November 2013. She has anxiety and major depressive disorder. She had physical therapy in 2013 and another course of therapy was started in February 2015. When seen, there was decreased right shoulder range of motion with positive impingement testing. There was right deltoid swelling. There was decreased lumbar spine range of motion. There was right knee tenderness with positive McMurray testing and joint line tenderness. There was decreased left lower extremity sensation with positive left straight leg raising. Diagnoses included right shoulder calcific tendinitis. Authorization for physical therapy and shockwave treatments was requested. The claimant is being treated for chronic pain with no new injury and has recently had physical therapy. Patients are expected to continue active therapies and compliance with an independent exercise program would be expected without a need for ongoing skilled physical therapy oversight. An independent exercise program can be performed as often as needed/appropriate rather than during scheduled therapy visits. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. Skilled therapy in excess of that necessary could promote dependence on therapy provided treatments. The request is not medically necessary.