

Case Number:	CM15-0172880		
Date Assigned:	09/15/2015	Date of Injury:	09/14/2010
Decision Date:	10/21/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/02/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 64 year old male with an industrial injury dated 09-14-2010. Medical record review indicates he is being treated for cervical disc syndrome, rupture or herniation of lumbar disc, tear of medial cartilage meniscus of the knee and 2 cm tear of the central portion of the supraspinatus tendon left shoulder. He presents on 07-16-2015 with complaints of left posterior shoulder, left cervical dorsal, upper thoracic, right cervical dorsal, right posterior shoulder, right anterior shoulder, left anterior shoulder, left anterior arm, right anterior arm, right anterior knee and left anterior knee pain. The discomfort was rated as 6 out of 10 being noticeable approximately 60% of the time. The discomfort is documented as 6 out of 10 at its worst and 4 out of 10 at its best. Documentation also notes numbness and tingling in left anterior leg, left anterior knee, left shin, left ankle, left foot, left posterior leg, left posterior knee, left calf, left ankle, left foot, right anterior hand, left anterior hand, left posterior hand and right posterior hand documented as noticed approximately 50% of the time. Physical exam noted "moderate" tenderness at lumbar 4 and lumbar 5. Lower extremity range of motion progress (12-22-2014-previous exam and 07-16-2015-current exam is as follows: Left knee flexion 1% change, left knee extension 33% change, Right knee flexion 3% change, right knee extension 33% change, Cervical flexion 17% change, cervical extension 26% change, Cervical lateral left 22% change, cervical lateral right 19% change, Cervical rotation left 46% change, cervical rotation right 17% change, Lumbar flexion 12% change, lumbar extension 0% change, Lumbar lateral left 25% change, lumbar lateral right 38% change. MRI of the right shoulder dated 10-31-2014

is documented as showing: (1) Oblique tear of the supraspinatus tendon with at least a 6 mm gap and fluid in the subacromial-sub deltoid bursa indicating a full thickness tear. (2) Horizontal tear of the superior glenoid labrum extending to the under surface of this structure. (3) Fluid surrounding the biceps tendon in the bicipital tendon groove which may represent tenosynovitis of this structure. MRI of the left shoulder dated 10-31-2014 is documented as showing: (1) 2 cm tear of the central portion of the supraspinatus tendon, at the insertion site, with fluid in the subacromial-sub deltoid bursa indicating a full thickness tear. (2) Fluid surrounding the biceps tendon in the bicipital tendon groove which may represent tenosynovitis. (3) Horizontal tear of the superior glenoid labrum extending to the under surface of this structure. Prior treatment included Prilosec and Naproxen. A pain cream was prescribed (Flurbiprofen, Baclofen, Dexamethasone, Menthol, Camphor, Capsaicin and Hyaluronic acid.). The requested treatment is for shockwave ultrasound. On 08-18-2015, the treatment for shockwave ultrasound was deemed not medically necessary by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave ultrasound: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck & Upper Back, Extracorporeal shock wave therapy.

Decision rationale: The patient presents with left posterior shoulder, left cervical dorsal, upper thoracic, right cervical dorsal, right posterior shoulder, right anterior shoulder, left anterior shoulder, left anterior arm, right anterior arm, right anterior knee, and left anterior pain. The current request is for shockwave ultrasound. The treating physician states, in a report dated 07/16/15, "Treatment plan: shock wave ultrasound." (25C) The MTUS guidelines are silent on shock wave therapy. ODG guidelines state, "Not recommended for back pain. The available evidence does not support the effectiveness of shock wave for treating back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." In this case, the treating physician, based on the records available for review, has prescribed a treatment modality that is clearly not recommended by the guidelines for the low back. Further, the request does not specify the body part requested. The current request is not medically necessary.