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| <b>Case Number:</b>   | CM15-0177687 |                              |            |
| <b>Date Assigned:</b> | 09/28/2015   | <b>Date of Injury:</b>       | 09/18/2008 |
| <b>Decision Date:</b> | 12/02/2015   | <b>UR Denial Date:</b>       | 08/27/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/09/2015 |

### 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: Washington, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 56 year old male who sustained an industrial injury on September 18, 2008. He reported right shoulder pain, right wrist and hand pain, medial and lateral right elbow pain, neck pain, low back pain left lower extremity symptoms as per a primary physicians report in 2014. The injured worker was diagnosed as status post right arthroscopy with debridement of labrum, status post right carpal tunnel release, status post cubital tunnel decompression, right lateral and medial epicondylitis, cervical spondylosis and cervical and lumbar disc protrusions on multiple levels with neural encroachment and radiculopathy. Treatment to date has included diagnostic studies, radiographic imaging, surgical intervention of the shoulder and wrist, chiropractic therapy, physical therapy, injections to the shoulder, TENS unit, low back brace (LSO), medications and work restrictions. Urine drug screens (6-4-15 and 7-13-15) showed inconsistent results: positive for use of benzodiazepines and negative for use of Norco. Evaluation on August 3, 2015, revealed continued right shoulder pain, right wrist and hand pain, medial and lateral right elbow pain, neck pain and low back pain with left lower extremity symptoms. He rated his neck pain at 7/10, low back pain at 6/10, right shoulder pain at 8/10, right wrist at 5/10 and lateral and medial right elbow at 5/10 on a 1-10 scale with 10 being the worst. Hydrocodone was prescribed. Shockwave therapy was recommended for shoulder MRI proven calcific tendonitis (initial request dated 6-1-15). Evaluation on August 24, 2015, revealed continued right shoulder pain, right wrist and hand pain, medial and lateral right elbow pain, neck pain and low back pain with left lower extremity symptoms with no change in his pain ratings. It documented the injured worker shoulders had failed physical therapy, right shoulder

injection, home exercises, bracing and NSAID therapy and was continuing to use Norco 3 times per day for pain without any side effects from this medication. The Request for Authorization included requests for urine drug screen, additional Chiro x 6, Norco 10/325mg #90, Postural Vest for Shoulders and Shockwave Therapy Right Shoulder 3 Sessions and was non-certified on the utilization review (UR) on August 27, 2015.

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

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

#### **Shockwave Therapy Right Shoulder 3 Sessions: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic): Extracorporeal shock wave therapy (ESWT) and Other Medical Treatment Guidelines 1) Bannuru, RR; Flavin, NE; Vaysbrot, E; Harvey, W; McAlindon, T. High-energy extracorporeal shock-wave therapy for treating chronic calcific tendinitis of the shoulder: a systematic review. *Ann Intern Med.* 2014 Apr 15;160 (8): 5429. 2) Mouzopoulos G1, Stamatakos M, Mouzopoulos D, Tzurbakis M. Extracorporeal shock wave treatment for shoulder calcific tendonitis: a systematic review. *Skeletal Radiol.* 2007 Sep 3. 6(9):803-11. Epub 2007 Apr 6. 3) American Academy of Orthopaedic Surgeons. Optimizing Management of Rotator Cuff Problems: Guideline and Evidence Report. Dec 20. 10 4) Wang CJ. Extracorporeal shockwave therapy in musculoskeletal disorders. *J Orthop Surg Res.* 2012 Mar 20. 7:11.

**Decision rationale:** Extracorporeal shockwave therapy (ESWT) is a method of treatment for multiple tendinopathies. Although its medical value is disputed, there are a growing number of random controlled studies showing its effectiveness for treating chronic calcific tendinitis of the shoulder, plantar fasciitis and tennis elbow. ESWT is also commonly used for treating orthopedic problems in horses, including tendon and ligament injuries, kissing spine, navicular syndrome, and arthritis. It is thought to work by a repeated shock wave creating microtrauma thus stimulating neo-vascularization (new blood flow) into the area treated. This new blood flow promotes tissue healing. On average, three consecutive treatments are required to produce maximal therapeutic benefit to the treated tissue although it may take 6 weeks or more to see the final healing benefits. The ACOEM guidelines suggest it as a treatment option for treating calcific tendinitis of the shoulder. This patient has been diagnosed as having calcific tendonitis of the shoulder. Use of this modality remains an option in therapy. Medical necessity for use of this treatment modality has been established. Therefore, the requested treatment is medically necessary.

#### **Additional Chiro x 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Manipulation.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Shoulder Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** Multiple studies have shown that manipulation is an effective therapy in acute and chronic musculoskeletal conditions. Manipulation is a passive treatment. Its use in chronic conditions, as required by the MTUS guidelines, necessitates documentation of functional improvement, that is, improvement in activities of daily living or a reduction in work restrictions. The MTUS recommends a trial of 6 visits over two weeks and, if effective, then continued therapy to a total of 18 visits. It is important to note that many studies have shown that the longer a patient has pain the less likely therapy will be effective and that manipulation effectiveness decreases over time. Additionally, chiropractic treatments, as with therapies, such as physical therapy, require fading of treatment frequency along with home, self-directed exercises. The request for chiropractic treatment for this patient was initiated during the patient's chronic pain period, that is, over 6 months after the injuries occurred. The provider did not comment on the effectiveness of prior chiropractic treatments, note any reduction of work restrictions from the prior treatments nor note the number of treatments already given. Given all the above information, medical necessity for continue chiropractic care has not been established. Therefore, the requested treatment is not medically necessary.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009, Section(s): Medications for chronic pain, Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction,.

**Decision rationale:** Hydrocodone-Acetaminophen (Norco) is a mixed medication made up of the short acting, opioid, hydrocodone, and acetaminophen, better known as Tylenol. It is recommended for moderate to moderately severe pain with usual dosing of 5-10 mg hydrocodone per 325 mg of acetaminophen taken as 1-2 tablets every 4-6 hours. Maximum dose according to the MTUS is limited to 4 gm of acetaminophen per day, which is usually 60-120 mg/day of hydrocodone. According to the MTUS opioid therapy for control of chronic neuropathic pain, while not considered first line therapy, is considered a viable alternative when other modalities have been tried and failed. When treating moderate to severe nociceptive pain, defined as non radicular pain caused by continual injury, the MTUS considers opioid therapy to be the standard of care. Success of this therapy is noted when there is significant improvement in pain or function. The risk with this therapy is the development of addiction, overdose and death. The pain guidelines in the MTUS directly address this issue and have outlined criteria for

monitoring patients to allow for safe use of chronic opioid therapy. There is no documentation in the records available for review that the provider has followed the above noted guidelines for the safe use of chronic opioids in that the provider did not document use of first-line medications before starting opioid therapy, document the effectiveness of the opioid medication, document the use/review of a patient contract for chronic use of opioids, or address the repeated abnormal urine drug screens for aberrant drug use. Considering all the above information, medical necessity/appropriateness of continued use of opioid medications has not been established. Therefore, the requested treatment is not medically necessary.

**Postural Vest for Shoulders:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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)/IntelliSkin posture garments; Low Back - Lumbar & Thoracic (Acute & Chronic)/Posture garments.

**Decision rationale:** A brace is a medical device classified as durable medical equipment and used to support, assist, facilitate, and/or stabilize a part of the body. It is an acceptable nonpharmacologic treatment used to help treat painful or unstable joints. When used for posture correction, the brace or garment is thought to improve posture, lessen pain and improve athletic performance. However, there are no quality clinical studies to support postural use of a brace or garment. ACOEM guidelines does not comment on postural garments use for treatment of shoulder injuries and the Official Disability Guidelines (ODG) does not recommend use of postural garments for treatment of shoulder or back injuries. The provider has requested this device for use in this patient's ongoing shoulder injuries. As there is no guideline support for this use, a postural vest for treatment of this patient's shoulder injuries is not an appropriate option in therapy. Medical necessity has not been established. Therefore, the requested treatment is not medically necessary.