

<b>Case Number:</b>	CM13-0030625		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	01/05/2001
<b>Decision Date:</b>	03/28/2014	<b>UR Denial Date:</b>	09/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 60-year-old male with a date of injury on 01/05/2001. The progress report dated 09/05/2013 by [REDACTED] indicates that the patient's diagnoses include: 1. Cervical spine disk bulges. 2. Thoracic spine strain possible nerve entrapment. 3. Lumbar spine strain. 4. Status post right shoulder surgery. 5. Status post upper back wound surgery x3. 6. Right wrist degenerative disease. 7. Right upper extremity radicular pain. 8. Widespread erythemic rash, resolved. The patient continues with neck pain, upper back pain, low back pain, right shoulder pain, and right wrist pain. The exam findings included: Applicant presents with a right wrist brace and low back brace. The request was made for three (3) sessions of shockwave therapy to the right shoulder and an interferential unit. Utilization review letter dated 09/23/2013 issued non-certification of this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Three (3) shockwave therapy sessions for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Extracorporeal shockwave therapy (ESWT)

**Decision rationale:** The patient continues to have right shoulder pain. The MTUS/ACOEM Guidelines indicate that some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. The treating physician does not provide any documentation to support that the patient has calcifying tendinitis of the shoulder. Careful review of the file containing 305 pages does not show X-ray, MRI or other diagnostic reports indicating calcific tendinitis of the shoulder. Review of physician reports does not make any reference to calcific tendinitis. The review shows that this patient received shockwave therapy for the cervical spine as well as the lumbar spine. The treater appears to be going through the body parts providing this treatment. The request for shockwave therapy for the shoulder is not supported by the guidelines. Therefore, recommendation is for denial.

**One (1) interferential unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** The patient continues to have neck pain, upper back pain, low back pain, right shoulder pain, and right wrist pain. The Chronic Pain Guidelines indicate that interferential stimulation is not recommended as an isolated intervention; however, if interferential stimulation is to be used anyway, patient selection criteria includes: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine, pain is ineffectively controlled due to diminished effectiveness of medications, or pain is ineffectively controlled with medications due to side effects, or history of substance abuse, or significant pain from postoperative conditions limits the ability to perform exercise programs, physical therapy treatment, or unresponsive to conservative measures, such as repositioning, heat/ice. If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The treating physician does not provide documentation to satisfy the requirements requested by the Guidelines. There is no documentation of increased functional improvement following prior interferential unit therapy. Therefore, recommendation is for denial.