

<b>Case Number:</b>	CM13-0043824		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/13/1990
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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 and is licensed to practice in Illinois. 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 73-year-old injured worker who reported a work related injury on 09/13/1990, specific mechanism of injury not stated. The patient presents for treatment of the following diagnoses: cervical spine sprain/strain with radiculitis, thoracic spine sprain/strain, lumbar sprain/strain with radiculitis, dorsal lumbar myofascial pain syndrome, bilateral shoulder sprain/strain, status post right shoulder subacromial decompression and anterior acromioplasty, bilateral elbow and wrist sprain/strain, bilateral ankle sprain/strain, status post arthroscopic surgery right knee, plantar fasciitis, depression, and insomnia. The clinical note dated 07/18/2013 revealed the patient was seen in clinic under the care of [REDACTED]. The provider documented the patient continued to present with complaints of pain to the cervical spine, mid upper back, low back, bilateral shoulders, bilateral elbows, and bilateral ankles with some improvement. The provider documented restricted range of motion throughout the cervical spine, thoracic spine, lumbar spine, bilateral shoulders, bilateral elbows, and bilateral ankles secondary to pain. The provider documented the patient was approaching maximum medical improvement. The provider indicated the patient was to continue with physical therapy of the right shoulder 3 times a week for 4 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve extracorporeal shockwave therapy (ESWT): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

**Decision rationale:** The Official Disability Guidelines (ODG) indicates extracorporeal shockwave therapy is recommended for calcifying tendinitis but not for other shoulder disorders. Additionally, a maximum of 3 therapy sessions over 3 weeks is supported if this intervention is, in fact, utilized. The clinical documentation submitted for review evidenced the patient had previously utilized ESWT for their chronic pain complaints sustained status post an unspecified work related injury in 1990. The clinical notes failed to document significant quantifiable evidence of positive efficacy with this intervention. The request for twelve extracorporeal shockwave therapies (ESWT) is not medically necessary and appropriate.