

<b>Case Number:</b>	CM13-0067698		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	04/11/2010
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/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 injured worker is a 41-year-old female who reported an injury on 05/16/2010 due to an unspecified mechanism of injury. The injured worker complained of right shoulder pain. The diagnoses included a cervical spine discopathy, rule out right upper extremity radiculopathy; rule out right shoulder impingement syndrome, right hand overuse syndrome, and right knee sprain/strain tendonitis. The past treatments included shock wave therapy, dated 01/19/2012, physical therapy, and medication. Prior surgery included a right shoulder arthroscopic. The diagnostics included an electromyogram and MRI, documentation not available for review. The objective findings, dated 09/19/2013, revealed right shoulder with sling, good range of motion, however, some pain noted. Evaluation revealed a scar consistent with arthroscopic surgery. The treatment plan included naproxen and gabapentin. The Request for Authorization, dated 01/30/2014, was submitted with documentation. Medications include Anaprox DS and tramadol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EXTRACORPOREAL SHOCKWAVE THERAPY FOR THE RIGHT MID TRAPEZIUS & BILATERAL SHOULDERS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

**Decision rationale:** The decision for extracorporeal shockwave therapy for the right mid trapezius & bilateral shoulders is not medically necessary. The Official Disability Guidelines recommend the ESWT for calcifying tendonitis, but not for other shoulder disorders. The criteria for the ESWT are patients whose pain from calcifying tendonitis of the shoulder has remained, despite 6 months of stand therapy. At least 3 conservative treatments have been performed prior to the ESWT. These would include rest, ice, NSAIDs, or orthotics, physical therapy, and injections. Contraindicated in pregnant women; patients younger than 18 years of age; patients with blood clotting disease, infection, tumors, cervical decompression, arthritis of the spine or arm, or nerve damage; patients with cardiac pacemakers; patients who have had physical or occupational therapy within the last 4 months; patients who received local steroid injection within the past 6 weeks; patients with bilateral pain; patients who had previous surgery for the condition. A maximum of 3 therapy sessions over 3 weeks. Per the documentation, the injured worker has had several surgeries to the right shoulder. Additionally, the documentation was not evident of the injured worker having steroid injections and if she has had them within the last several weeks. As such, the request is not medically necessary.

**CONDROLITE 500/200/150 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

**Decision rationale:** The request for Condrolite 500/200/150 mg #90 is not medically necessary. The California MTUS recommend as an option given its low risk, inpatients with moderate arthritis pain, especially for knee osteoarthritis. The clinical notes did not indicate that the injured worker has a diagnosis of arthritis pain. The injured worker's complaint was right shoulder pain. The request did not address frequency. As such, the request is not medically necessary.