

<b>Case Number:</b>	CM14-0014837		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 Management and is licensed to practice in Tennessee. 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 patient is a 62-year-old male who has submitted a claim for right shoulder signs and symptoms with rotator cuff tear associated with an industrial injury date of July 31, 2013. The patient complained of right shoulder pain radiating down the lateral aspect of the right arm, elbow, wrist, hand and middle and ulnar fingers. Physical examination of the right upper extremity showed tenderness over the acromioclavicular joint and superior deltoid of the right shoulder and right ulnar and volar wrist; positive Hawkin's, Neer's, Tinel's at the elbow and wrist, and Phalen's; positive Flick's and Durkan's tests; limitation of motion of the shoulder and wrist; and decreased sensation in the right C5-6 distribution. MRI of the right shoulder done on December 26, 2013 revealed a 6.7mm partial-thickness articular surface tear of the distal supraspinatus tendon; while MRI of the right wrist documented possible vertical and oblique tear of the outer margin of the triangular fibrocartilagenous complex. EMG and NCS of the bilateral upper extremities on November 14, 2013 documented bilateral carpal tunnel syndrome and right ulnar sensory mononeuropathy. The diagnoses were right shoulder signs and symptoms with rotator cuff tear; right elbow ulnar neuropathy; right wrist signs and symptoms with TFCC tear and right carpal tunnel syndrome. Treatment plan includes a request for shockwave therapy of the right wrist, elbow and shoulder. Treatment to date has included oral and topical analgesics and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SHOCK WAVE THERAPY X 3 (RIGHT WRIST, ELBOW AND SHOULDER): Upheld**

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

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

**Decision rationale:** According to page 203 of the ACOEM Practice Guidelines referenced by CA MTUS, physical modalities, such as ultrasound treatment, etc. are not supported by high-quality medical studies. ODG recommended extracorporeal shockwave therapy for calcifying tendinitis but not for other shoulder disorders. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders. ODG also states that ESWT for the elbow is not recommended unless there is pain from lateral epicondylitis (tennis elbow) that has remained despite six months of standard treatment. In this case, the above mentioned conditions were not found in this patient. There was also no evidence of trial and failure of the conservative management to relieve pain. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request is not medically necessary.