

<b>Case Number:</b>	CM14-0155155		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	10/21/2010
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Pain Medicine, and is licensed to practice in Minnesota. 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 male who reported an injury on 10/21/2010. He was reportedly emptying a container and loading boxes onto a pallet when his foot went through a space between a container and a ramp, and he fell backyards. On 09/08/2014, the injured worker presented with low back and left knee pain. Upon examination of the left knee, there was a surgical scar noted. There was tenderness to palpation noted over the patellar medial and lateral joint lines. Manual muscle testing revealed 4/5 strength with flexion and extension, and range of motion restricted due to pain. The diagnoses were left knee internal derangement and status post left knee arthroscopy x2 in 2011 and 2012. Prior therapy included acupuncture and medications. The provider recommended electrostatic wave therapy 1 time a week for 6 to 12 weeks. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ESWT (electric shockwave therapy) 1/week for 6-12 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 201-205.

**Decision rationale:** The request for electro shockwave therapy 1 time a week for 6 to 12 weeks is not medically necessary. The California MTUS/ACOEM Guidelines state that some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shockwave therapy for calcifying tendonitis of the shoulder. Initial use of less invasive techniques provides an opportunity for the clinician to monitor progress before a referral to a specialist. There was a lack of physical exam findings of functional deficits related to the injured worker and lack of documentation of the other treatments the injured worker underwent previously, and measurements of progress with the prior treatments. The provider's request does not indicate the site at which electro shockwave therapy was indicated for the request as submitted. As such, medical necessity has not been established.