

Case Number:	CM14-0021584		
Date Assigned:	05/05/2014	Date of Injury:	01/14/2008
Decision Date:	07/09/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/20/2014

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 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 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:

This patient is a 55-year-old male with date of injury of 01/14/2008. Per treating physician's report, 12/19/2013, the listed diagnoses are bilateral shoulder tendinitis, cervical spine DDD syndrome, right shoulder pain, lumbosacral and thoracic spine sprain/strain. The patient presents with pain in the shoulder, neck, and low back. This report is handwritten and difficult to read, but describes under objective, MRI of the right shoulder and left shoulder showing supraspinatus tendinosis and synovial cyst. There is a report for ESWT dated 11/21/2013 and treatment was for mid-back region. The request was denied by Utilization Review letter dated 02/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 1 SHOCKWAVE THERAPY TO THE THORACIC SPINE DOS: 10/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines EXTRACORPOREAL SHOCKWAVE THERAPY.

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

guidelines has the following regarding ESWT:(<http://www.odg-twc.com/odgtwc/ankle.htm#Protocol>).

Decision rationale: This patient presents with chronic neck, thoracic, and low back pain along with shoulder pain. The treating physician has provided ESWT or shockwave therapy to the thoracic spine on 10/10/2013. Per ODG Guidelines, while ESWT treatments are indicated for epicondylitis, plantar fasciitis, calcific tendinitis of the shoulder, it is not supported for spinal conditions. Recommendation is for denial. The request is not medically necessary and appropriate.