

<b>Case Number:</b>	CM14-0021728		
<b>Date Assigned:</b>	05/12/2014	<b>Date of Injury:</b>	01/22/2013
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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:

The patient is a 38 year old with an injury date on 1/22/13. Based on the 1/6/14 progress report provided by [REDACTED] the diagnoses are: 1. C-spine sprain/strain. 2. T-spine sprain/strain. 3. Rotator cuff syndrome. 4. Neuritis/radiculitis. Exam on 1/6/14 showed "Paraspinal edema, intersegmental motion restrictions, spinous process tenderness, bilateral thermal asymmetries were present locally at the injured spinal levels and correlated well with radiographic examinations. Slight decrease in cervical range of motion with associated pain with right and left lateral flexion and right rotation. Slight decrease with left shoulder range of motion with positive orthopedic tests." [REDACTED] is requesting extracorporeal shockwave therapy x 7 visits for the left shoulder. The utilization review determination being challenged is dated 1/15/14. [REDACTED] is the requesting provider, and he provided treatment reports from 7/17/13 to 1/6/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **EXTRACORPOREAL SHOCKWAVE THERAPY X 7 VISITS FOR THE LEFT SHOULDER: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines INITIAL CARE.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, ESWT.

**Decision rationale:** This patient presents with neck pain/stiffness radiating to left upper extremity, left shoulder pain, upper back pain. The treating physician has asked extracorporeal shockwave therapy on 1/6/14. 10/9/13 report shows patient had six sessions of chiropractic therapy and deep myofascial release therapy with minimal improvement and continuing left neck and left shoulder pain radiating into left upper extremity. Regarding shockwave therapy for the shoulder, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) recommends for calcifying tendinitis but not for other shoulder disorders with maximum of 3 therapy sessions over three weeks. In this case, patient does not exhibit symptoms of calcifying tendinitis. Furthermore, the treating physician has asked for seven sessions of extracorporeal shockwave therapy, which exceeds ACOEM guidelines for this type of condition. The requesting treatment is not medically necessary and appropriate.