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| Case Number: | CM14-0056972 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 03/23/2007 |
| Decision Date: | 08/22/2014 | UR Denial Date: | 04/11/2014 |
| Priority: | Standard | Application Received: | 04/28/2014 |

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 and Pain Medicine and is licensed to practice in Texas. 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 58 year old female injured on 03/23/07 due to undisclosed mechanism of injury. Current diagnoses included status post left shoulder surgery in 2007 and lumbar spine disc bulges. Clinical note dated 02/06/14 indicated the injured worker presented complaining of low back pain rated 9/10, left greater than right. Objective findings included decreased range of motion in the lumbar spine and decreased sensation of L5 dermatomes. Prescriptions for Soma, Ambien, and Norco provided. The initial request for shockwave therapy one times nine to low back and left shoulder was non-certified on 04/11/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave Therapy one (1) time a week for nine (9) weeks to low back and left shoulder:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

Decision rationale: Transcutaneous electrical nerve stimulation (TENS) use is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be

considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for TENS use includes documentation of pain of at least three months duration; evidence that other appropriate pain modalities have been tried and failed; a one-month trial period of the TENS unit should be documented with how often the unit was used and the outcomes in terms of pain relief and function; rental would be preferred over purchase during trial; ongoing pain treatment should also be documented during the trial including medication usage and a treatment plan including the specific short- and long-term goals of treatment with the unit should be submitted. The documentation did not meet the required criteria. As such, the request is not medically necessary.