

<b>Case Number:</b>	CM15-0008257		
<b>Date Assigned:</b>	01/23/2015	<b>Date of Injury:</b>	09/21/2013
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 65 year old male, who sustained an industrial injury on 9/21/2013. The mechanism of injury has not been provided with the clinical documentation submitted for review. The diagnoses have included cervical spine pain, cervical spine radiculopathy, cervical spine displacement, left shoulder sprain/strain, left shoulder internal derangement, left shoulder lateral epicondylitis, left wrist carpal tunnel syndrome, lumbar spine sprain/strain, lumbar spine pain, lumbar spine radiculopathy and lumbar disc displacement. Treatment to date has included physical therapy, acupuncture, specialist consultation, activity modifications and medications. Currently, the Injured Worker complains of constant, moderate to severe, burning radicular neck pain, greater on the left side. The pain is rated as a 6/10. He also reports constant moderate to severe burning left shoulder pain radiating down the arm to the fingers. He reports constant moderate to severe burning left wrist pain rated as a 7-8/10. He reports constant moderate to severe low back pain rated as 8/10. The pain is associated with numbness and tingling of the bilateral lower extremities. The pain is rated as 7/10. Medication offers some temporary relief. Objective findings included tenderness to palpation of the cervical spine, lumbar spine, left shoulder, left elbow and left wrist. There is decreased range of motion. On 12/23/2014, Utilization Review non-certified a request for extracorporeal shockwave therapy (1x week x12 weeks) for the lumbar spine, cervical spine, and left shoulder noting that the treatment requested is not substantiated for this clinical presentation. The ODG was cited. On 1/13/2015, the injured worker submitted an application for IMR for review of extracorporeal shockwave therapy (1x weekx12 weeks) for the lumbar spine, cervical spine, and left shoulder

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Extracorporeal Shockwave Therapy 1 Time A Week for 12 Weeks to The Lumbar Cervical, Left Shoulder: 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter under shockwave therapy shoulder chapter under shockwave therapy

**Decision rationale:** According to the 11/06/2014 report, this patient presents with a 6/10 constant moderate to severe radicular neck pain, 7/10 constant moderate to severe radicular left shoulder pain, and an 8/10 constant moderate to severe radicular low back pain. The current request is for Extracorporeal shock wave therapy 1 time a week for 12 weeks to the lumbar cervical, left shoulder. The patient's work status is remain off work; TTD from 11/06/2014 to 12/04/2014. Regarding lumbar and cervical ESWT, MTUS and ODG does not discuss ESWT for the cervical spine, however ODG guidelines does discuss ESWT for the lumbar spine. ODG states not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011). The request IS NOT medically necessary. Regarding shoulder ESWT, MTUS does not discuss ESWT for the shoulder, however ODG guidelines does discuss ESWT, Extracorporeal shock wave therapy (ESWT) has been suggested to be an effective treatment option for treating calcific tendinitis of the shoulder before surgery, but after conservative treatments, including physical therapy, iontophoresis, deep friction, local or systemic application of noninflammatory drugs, needle irrigation-aspiration of calcium deposit, and subacromial bursal steroid injection. In reviewing the reports provided, the treating physician does not document "calcific tendinitis of the shoulder. There was no documentation of conservative treatments, including physical therapy, iontophoresis or deep friction found in the medical records provided. The examination shows tenderness at the trapezius, levator scapular, rhomboid muscles, and left AC joint with decreased range of motion. The requested shockwave therapy for the left shoulder without documentation of "calcific tendinitis is not supported by ODG guidelines. Therefore, the request IS NOT medically necessary.