

Case Number:	CM15-0101919		
Date Assigned:	06/04/2015	Date of Injury:	09/05/2014
Decision Date:	07/03/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/27/2015

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: Preventive Medicine, Occupational Medicine

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 46-year-old female, who sustained an industrial injury on 9/5/2014. She reported injury while loading large containers of ice cream. The injured worker was diagnosed as having left shoulder impingement syndrome, left shoulder acromioclavicular degenerative joint disease and chronic lumbago. Lumbar magnetic resonance imaging showed small disc protrusions and left shoulder magnetic resonance imaging showed a small lipoma and a partial thickness tear of the subscapular tendon. Treatment to date has included physical therapy and medication management. In a progress note dated 3/11/2015, the injured worker complains of left shoulder pain and low back pain rated 8/10 without medications and 5-6/10 with medications. Physical examination showed tenderness to palpation of the left shoulder. The treating physician is requesting 6 sessions of ultrasonic shockwave therapy for the left shoulder and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasonic Shockwave therapy, 1 time per wk for 6 wks, Left shoulder, Lumbar spine (6 sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter/Shock Wave Therapy Section.

Decision rationale: The MTUS Guidelines do not address the use of extracorporeal shock wave therapy to the lumbar spine. The ODG does not recommend the use of shock wave therapy as the available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. The request for Ultrasonic Shockwave therapy, 1 time per wk for 6 wks, Left shoulder, Lumbar spine (6 sessions) is determined to not be medically necessary.