

<b>Case Number:</b>	CM14-0116897		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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 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 injured worker is a 57-year-old female who reported an injury on 07/24/2013 due to cumulative trauma. On 05/27/2014, the injured worker presented with complaints of pain related to the bilateral shoulders, bilateral elbows, bilateral wrists, bilateral knee, and bilateral ankles. Upon examination, there was a positive bilateral Kemp's test and a negative straight leg raise bilaterally. There was positive paraspinal tenderness. The diagnoses were mild bilateral neural foraminal narrowing lordosis of the cervical spine, thoracic spine spondylosis, lumbar spine mild degenerative disc disease, bilateral spine right AC osteoarthritis/tendonitis and elbow, wrist and knee rule out internal derangement. The provider recommended shockwave therapy to the lumbar and thoracic. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**shock Wave therapy lumbar/thoracic:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): shock wave therapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The request for shockwave therapy of the lumbar/thoracic is not medically necessary. The California MTUS/ACOEM Guidelines state there is some medium quality evidence to support manual physical therapy, ultrasound and high energy extra corporeal shockwave therapy for calcifying tendinitis of the shoulder. Initial use of less invasive techniques provides an opportunity for the clinician to monitor progress before referral to a specialist. There was lack of information of physical exam and lack of documentation of whether treatments the injured worker underwent previously and the measurements of progress of the prior treatments. As such, medical necessity has not been established.