

<b>Case Number:</b>	CM13-0059027		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	04/06/2010
<b>Decision Date:</b>	06/12/2015	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2013

### 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: Arizona, Texas  
 Certification(s)/Specialty: Internal 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 62 year old female, who sustained an industrial injury on 4/06/2010. Diagnoses include cervical spine disc bulge, thoracic spine strain, lumbar spine disc bulge, status post left shoulder surgery, right elbow strain, left elbow strain, right wrist/hand strain, left wrist/hand strain, left hip pain, right knee strain, left knee strain, bilateral ankle strain and right plantar fasciitis. Treatment to date has included surgical intervention (left shoulder subacromial bursectomy and acromioplasty 9/15/2012) transforaminal epidural steroid injections, diagnostics, medications and activity modification. Per the Primary Treating Physician's Progress Report dated 9/25/2013, the injured worker reported elbow pain for the past three months and neck pain that is described as getting worse. She reports pain radiating to all 10 fingers and increasing upper extremity numbness and tingling. Physical examination revealed right lateral shoulder sensation intact, right thumb tip diminished, and right small tip diminished. The plan of care included diagnostic testing, consultations and shockwave therapy. Authorization requested for shockwave therapy (2x6) for the neck, left shoulder and right ankle.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SHOCKWAVE THERAPY SESSIONS, TWICE A WEEK FOR SIX (6) WEEKS FOR NECK, LEFT SHOULDER AND RIGHT ANKLE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, CHAPTER ( SHOULDER COMPLAINTS ) AND CHAPTER (ANKLE AND FOOT COMPLAINTS), 555-556,1044-1046.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 368.

**Decision rationale:** According to the ACOEM, limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in treating plantar fasciitis to reduce pain and improve function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Furthermore, conservative care is required for chronic shoulder pain only after alternative treatments have failed. In this case the documentation doesn't support that the patient has failed alternative treatments sufficient to qualify for ECSW therapy for the shoulder. The request is not medically necessary.