

<b>Case Number:</b>	CM15-0175512		
<b>Date Assigned:</b>	09/16/2015	<b>Date of Injury:</b>	03/03/2003
<b>Decision Date:</b>	10/26/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2015

### 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, North Carolina  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 58-year-old male worker who was injured on 3-3-2003. The medical records indicated the injured worker (IW) was treated for cervical spine disc rupture; thoracic spine strain; lumbar spine disc rupture; right shoulder surgery; right knee internal derangement; and left knee strain. The progress notes (7-28-15) indicated the IW had pain in the neck, upper and lower back, right shoulder, and the bilateral knees. He stated he had a lumbar epidural steroid injection (LESI) in December of 2014 that helped decrease his pain for two months. On physical examination, (7-28-15) light touch sensation was intact to the right anterior thigh, right mid lateral calf and right lateral ankle. An orthopedic evaluation (6-29-15) stated the IW had right shoulder surgery on 1-6-15, followed by physical therapy. He also used a TENS unit for his neck, lower back and knee pain with temporary relief. Physical therapy notes (5-18-15) indicated the IW had postoperative physical therapy (at least 11 visits) for the right shoulder and home exercise program. Other notes (6-4-15 record) stated a bilateral L5-S1 LESI provided greater than 50% pain relief for over five months and enabled him to return to work; he was working light duty. A Request for Authorization was received for six additional post-op PT visits for the right shoulder, once a week for six weeks and 12 shockwave therapy visits for the cervical and lumbar spine. The Utilization Review on 8-17-15 non-certified the request for six additional post-op PT visits for the right shoulder, once a week for six weeks due to lack of documentation about the surgery; 12 shockwave therapy visits for the cervical and lumbar spine was non-certified due to lack of clinical indications for this treatment to areas of the body not recommended by CA MTUS, ACOEM and ODG guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the right shoulder, once a week for six weeks:** 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-TWC).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** CA MTUS supports physical therapy in the post-operative period in order to restore flexibility, strength, endurance, function, range of motion and to alleviate discomfort. In this case, the claimant complains of neck, upper back, low back, right shoulder and bilateral knee pain. There is a history of right shoulder arthroscopy, however the date and type of procedure is not provided. The request is for physical therapy to the right shoulder. There is no documentation of prior physical therapy. Therefore, without information regarding date of surgery, type of surgery, and number of PT sessions completed, the request is not medically necessary.

**Other shock wave therapy for the lumbar and/or sacral vertebrae (vertebra NOC trunk):**  
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-TWC).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

**Decision rationale:** ACOEM Guidelines state that ESWT therapy is not recommended for low back conditions. It may be recommended for elbow and shoulder conditions and plantar fasciitis. In this case, the patient complains of chronic low back pain. The request is for shock wave therapy for the lumbar/sacral vertebrae. There is no evidence that ESWT is effective for low back pain. There are no specific findings indicating the need for ESWT outside the recommended guidelines. Therefore, the request is not medically necessary or appropriate.