

<b>Case Number:</b>	CM13-0019791		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	02/25/2013
<b>Decision Date:</b>	01/08/2014	<b>UR Denial Date:</b>	08/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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.

### 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 patient is a 44-year-old who reported an injury on 02/25/2013. The mechanism of injury is indicated as lifting of a box when the patient bent down and felt a cramp in the back and had continued back pain. The most recent evaluation of the patient on 09/18/2013 details subjective complaints of lower back pain verbalized as 5/10 on the visual analog scale for pain, and constant pain was noted in the gluteal region. Physical examination of the patient noted that Kemp's test, Yeoman's test, and Milgram's tests were positive on both sides. Straight leg raise in the supine position was positive on the right and left. Reflexes were noted to be normal in the bilateral knees and ankles. There was no indicated loss of sensation in any dermatomal distribution of the lower extremities, with normal strength noted throughout the bilateral lower extremities. On palpation, the patient had moderate paraspinal tenderness, muscle guarding, and spasms indicated at T12 through S1. Range of motion of the lumbar spine was indicated at 35 degrees, extension 15 degrees, lumbar spine lateral bending 20 degrees on the right and 15 degrees on the left with lumbar spine rotation of 15 degrees on the right and 25 degrees on the left. Recommendation was made for the patient to receive shockwave therapy to the lumbar spine once per week for 6 weeks with an additional recommendation for a psychiatric evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shock wave therapy on the lumbar spine, once per week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** The Physician reviewer's decision rationale: The Official Disability Guidelines state that shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. While the documentation submitted for review details that the patient has subjective complaints of pain to the lumbar spine and gluteal region as well as complaints of difficulty falling asleep, nighttime awakening secondary to pain, and anxiety secondary to pain, the documentation also indicates that the patient has undergone acupuncture treatment and an epidural steroid injection on 08/05/2013. Nonetheless, there is a lack of clear clinical rationale submitted in the medical records indicating necessity for shockwave therapy for the patient. Furthermore, the referenced guidelines indicate that shockwave therapy is not supported as there is a lack of evidence of its effectiveness in treating low back pain. The request for shock wave therapy on the lumbar spine is not medically necessary or appropriate.

**psychological evaluation with Dr. Grewal:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, psychological evaluations are generally accepted, well established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. While the documentation submitted for review indicates that the patient has difficulty attaining and maintaining sleep secondary to pain, as well as anxiety secondary to pain, there is a lack of documentation submitted for review indicating that the patient has significant psychopathology or other serious medical comorbidity to support the recommendation for psychological evaluation. Furthermore, the most recent clinical notes submitted for review dated 09/18/2013 indicated the patient was recommended for follow-up with an occupational medicine consultation with [REDACTED] to address his injury and for possible prescription of pain medication. However, there is a lack of documentation submitted for review indicating that the patient has completed this consultation and to determine the patient's functional response and addressing the patient's pain complaints following prescription of pain medication. The request for a psychological evaluation with [REDACTED] is not medically necessary or appropriate.