

Case Number:	CM13-0021962		
Date Assigned:	11/13/2013	Date of Injury:	06/20/2012
Decision Date:	05/08/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a 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 & Rehabilitation, has a subspecialty in Interventional Spine, 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. 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 patient is a 53-year-old female with date of injury of 06/20/2012. The listed diagnoses according to [REDACTED] dated 07/10/2013 are: 1. Bilateral wrist carpal tunnel syndrome 2. Bilateral wrist De Quervain's tenosynovitis 3. Lumbar spine HNP 4. Lumbar radiculopathy 5. Bilateral ankle sprain/strain 6. Anxiety disorder 7. Mood disorder 8. Sleep disorder According to the progress report dated 07/10/2013, the patient complains of low back pain. She rates her pain as 8/10. She describes her pain as frequent, constant, moderate to severe. The patient states that there is radiating pain, numbness, and tingling to the right lower extremity. The physical examination of the lumbar spine shows there is palpable tenderness noted in the right PSIS. There is bilateral paraspinal muscle guarding noted. The patient is able to squat to approximately 10% of normal due to pain. Her lumbar range of motion is severely decreased. Straight leg raise is positive on the right at 35 degrees and positive on the left at 45 degrees. Braggard's test is also positive bilaterally. There is diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. The treating physician is requesting an extracorporeal shock wave therapy for 12 weeks for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXTRACORPOREAL SHOCKWAVE THERAPY 1X6-12 WEEKS, LUMBAR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation

[HTTP://WWW.EQUINEPI.COM/SERVICES/ESWT.HTML](http://www.equinepi.com/services/eswt.html),

[HTTP://DOGAWARE.COM/ARTICLES/WDJSHOCKWAVE.HTML](http://dogaware.com/articles/wdjs shockwave.html)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.

Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) NOT RECOMMENDED. THE AVAILABLE EVIDENCE DOES NOT SUPPORT THE EFFECTIVENESS OF ULTRASOUND OR SHOCK WAVE FOR TREATING LBP. IN THE ABSENCE OF SUCH EVIDENCE, THE CLINICAL USE OF THESE FORMS OF TREATMENT IS NOT JUSTIFIED AND SHOULD

Decision rationale: This employee presents with chronic low back pain. The treating physician is requesting an extracorporeal shock wave therapy for 12 weeks for the lumbar spine. The MTUS and ACOEM Guidelines are silent with regard to the request. However, the ODG Guidelines on shock wave therapy states it is "not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." Given the lack of support from the guidelines, recommendation is for denial.