MAXIMUS Federal Services

Case Number:	CM13-0066353		
Date Assigned:	01/03/2014	Date of Injury:	12/19/2012
Decision Date:	04/09/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/16/2013

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 Occupational Medicine 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:

This is a 48-year old female employed with the [redacted] who sustained injury on 12/19/2012 when she was transferring a 300 pound client from a car to a wheelchair. Medical records were reviewed dating from January 2013 to December 2013, during which period the patient repeatedly presented with persistent left knee pain, low back pain, and radiating pain complaints to the lower extremity. Physical exam findings included antalgic gait referred to the left lower extremity, left knee extension weakness. The patient has completed 24 PT visits, has had attempts at medication and activity modification. She was fitted with a knee brace and has performed home exercise. PT progress reports indicate that the patient's lumbar ROM has improved with PT. Imaging reports indicate facet hypertrophy at L4-5 and L5-S1. A request for corporeal ortho shockwave therapy one (1) time a week for six (6) weeks for the lumbar spine was non-certified on 11/20/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

CORPOREAL ORTHO SHOCK WAVE THERAPY 1 TIME A WEEK FOR 6 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),Low Back Chapter, Shockwave Therapy

Decision rationale: While CA MTUS is silent on the issue, ODG states that shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock waves for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The requesting physician failed to establish compelling circumstances identifying why ESWT for the low back unit be required despite adverse evidence. Therefore, the request was not medically necessary.