

Case Number:	CM14-0018407		
Date Assigned:	04/18/2014	Date of Injury:	06/25/2012
Decision Date:	07/24/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/13/2014

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. The expert 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 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/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 41-year-old male patient with a 6/25/12 date of injury. The 10/1/13 progress report indicates ongoing low back pain radiating to the lower extremities; worse on the right. Physical exam demonstrates tenderness and spasm over the lumbar and cervical spine. He has limited lumbar and cervical range of motion. The 10/21/13 progress report indicates persistent neck, bilateral wrists, and lower back pain. Physical exam demonstrates tenderness over the cervical and lumbar spine, decreased upper extremity motor strength secondary to pain, lumbar tenderness and spasm, and decreased bilateral lower extremity motor strength secondary to pain. The 11/12/13 progress report indicates persistent neck and low back pain, difficulty sleeping. Physical exam demonstrates cervical and lumbar tenderness. The 12/15/13 medical report indicates persistent neck, bilateral wrist, low back pain. Physical exam demonstrates lumbar tenderness, decreased bilateral lower extremity motor strength secondary to pain. Treatment to date has included pain medication, acupuncture, activity modification, and shockwave therapy to the wrist. There is documentation of a previous 1/20/14 adverse determination for lack of a rationale to support a probable benefit with shockwave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOCKWAVE TREATMENT TO LUMBAR SPINE, X3: 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) ODG (Low Back Chapter) Shockwave Therapy.

Decision rationale: CA MTUS does not apply. ODG states that shockwave 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. The requesting physician did not establish compelling circumstances identifying why Energy Shock Wave Therapy for the low back unit be required despite adverse evidence. Therefore, the request for Shockwave Treatment To Lumbar Spine, x3 is not medically necessary.