

Case Number:	CM14-0150660		
Date Assigned:	09/18/2014	Date of Injury:	10/07/2013
Decision Date:	10/22/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/16/2014

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 Family Practice and is licensed to practice in Texas and Mississippi. 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:

The injured worker is a 62-year-old male who reported injuries due to heavy lifting on 10/07/2013. On 04/10/2014, his diagnoses included lumbar ligament sprain, rule out disc displacement; rule out lumbar radiculopathy; right groin pain, rule out inguinal hernia; pain in right testicle, rule out varicocele; GERD; irritable bowel syndrome; diabetes mellitus; hypertension; and sleep disorder. His complaints included sharp stabbing low back pain with muscle spasms rated at 8/10. The pain radiated to his bilateral lower extremities with numbness and tingling. He had further complaints of right groin pain rated at 8/10 to 9/10. The pain was aggravated by anything that increased the intra-abdominal pressure, such as coughing or sneezing. He also had complaints of right testicle pain rated at 6/10 to 7/10. His pain often awakened him from his sleep. He stated that his pain was alleviated with medications, rest, and activity restriction. His lumbar spine ranges of motion measured in degrees were flexion 15/60, extension 10/25, left lateral flexion 10/25, and right lateral flexion 15/25. He had positive straight leg raising tests at 45 degrees bilaterally, and positive sitting root, and Kemp's tests. Among his treatment plan recommendations were a course of shockwave therapy up to 6 treatments for the lumbar spine. There was no rationale included in this injured worker's chart. A request for authorization dated 04/10/2014 was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy 1 times 6-12 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, low back Shock wave therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Low Back, Lumbar & Thoracic, Shock wave therapy.

Decision rationale: The Official Disability Guidelines do not recommend shockwave therapy. The available evidence does not support the effectiveness of ultrasound or shockwave treatment for lower back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Additionally, the body part or parts to have been treated were not specified in the request. Therefore this request for extracorporeal shockwave therapy 1 time 6 to 12 weeks is not medically necessary.