

<b>Case Number:</b>	CM14-0081035		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	03/27/2010
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	05/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient with a date of injury of March 27, 2010. A utilization review determination dated May 13, 2014 recommends denial of 12 shockwave therapy visits for the thoracic and lumbar spine. A progress report dated April 9, 2014 identify subjective complaints of pain in the neck, upper back, lower back, left shoulder, left knee, and right ankle. Physical examination identifies diminished light touch sensation in the left lower extremity. Diagnoses include a cervical spine strain, thoracic spine strain, lumbar spine strain, status post left shoulder surgery, left knee strain, and right ankle strain. The treatment plan states that the patient does not want surgical treatment and wants a lumbar epidural injection. The treatment plan goes on to recommend shockwave therapy for the thoracic and lumbar spine 2 times a week for 6 weeks. A neurology consultation and pain management follow-up are also recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Shockwave Therapy visits for thoracic and lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Low Back Procedure Summary.

**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, Shock wave therapy.

**Decision rationale:** Regarding the request for shockwave therapy for lumbar and thoracic spine, California MTUS does not address the issue. ODG does not address the issue for the thoracic spine, but cites that it is not recommended for the lumbar spine as the available evidence does not support its effectiveness in treating low back pain. [REDACTED] notes that shockwave for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested shockwave therapy for lumbar and thoracic spine is not medically necessary and appropriate.