

<b>Case Number:</b>	CM14-0129359		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	01/17/2014
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 51-year-old female who reported an injury on 01/17/2014 due to an unspecified mechanism of injury. On 06/23/2014, she presented for a followup evaluation. It was noted that she reported stabbing pain that radiated into the left leg and foot with associated numbness, tingling, and weakness. She reported pain in the bilateral shoulders, cervical spine rated at a 2/10 and thoracic and lumbar spine rated at a 6/10. A physical examination showed midline and lumbar tenderness to palpation with spasm and positive sciatic notch bilaterally. She had decreased active range of motion with pain. She was diagnosed with herniated nucleus pulposus of the cervical spine, sprain and strain of the thoracic spine, herniated nucleus pulposus of the lumbar spine, and osteoarthritis and tendinitis of the bilateral shoulders. It should be noted that the document provided was handwritten note and mostly illegible. The treatment plan was for extracorporeal shock wave therapy 1 to 2 times a week x 4 weeks to the cervical and thoracic spine and a nerve conduction study of the right lower extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Extracorporeal Shockwave Therapy 1-2x week x 4 weeks cervical spine, thoracic spine:**  
 Upheld

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

<http://www.ncbi.nlm.nih.gov/pubmed/21139662> extracorporeal shockwave therapy(ESWT) and radial extracorporeal pressure-wave therapy (rESWT) (heim k1) (Gjersing L) (Bistad K) (Risberg MA) 2010 Dec 2;130(23):2360-4.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 201-205.

**Decision rationale:** According to the California ACOEM Guidelines, extracorporeal shock wave therapy is only indicated and recommended for the shoulder. There is nothing to support this therapy in the cervical and thoracic spine. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding upper, mid, and low back as well as the bilateral shoulders; however, the guidelines do not support extracorporeal shock wave therapy for the cervical and thoracic spine. Also, it would appear as though the injured worker has already undergone extracorporeal shock wave therapy; however, there is a lack of documentation showing that she has had quantitative decrease in pain or an objective improvement in function with the therapy to support additional sessions. Therefore, the request is not supported. As such, the request is not medically necessary.

**Nerve Conduction Velocity (NCV) of the right lower extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 07/03/14) EMGs (electromyography)(Dimopoulos,2004) (AMA, 2001) ODG Nerve Conduction Studies (NCS) (Utah, 2006) (Charles, 2013)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-305.

**Decision rationale:** According to the California ACOEM Guidelines, unequivocal evidence that identifies specific nerve compromise on the neurologic examination is sufficient evidence to warrant imaging in those who do not respond to treatment. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the lumbar spine, mid back, upper back, and bilateral shoulders; however, there is a lack of documentation indicating that she has any significant neurological deficits to support the requested intervention. Also, there is a lack of evidence showing that she has tried and failed recommended conservative therapy options. Therefore, the request is not supported. As such, the request is not medically necessary.