Case Number:	CM15-0141445		
Date Assigned:	07/31/2015	**Date of Injury:**	08/01/2013
Decision Date:	08/28/2015	**UR Denial Date:**	07/15/2015
Priority:	Standard	**Application Received:**	07/21/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 35 year old male who sustained a repetitive industrial injury to his back and elbow on 08/01/2013. The injured worker was diagnosed with cervical spine multi-level disc displacement and degeneration with radiculopathy, right elbow lateral epicondylitis and partial tear of the common extensor tendon, thoracic spine scoliosis, lumbar spine spondylolisthesis, lumbar stenosis and radiculopathy, anxiety and sleep disorder. No surgical interventions were documented. Treatment to date has included diagnostic testing, physical therapy, trigger point impedance imaging and localized intense neurostimulation (LINT) therapy times 6 procedures, extracorporeal shockwave therapy to the thoracic spine times 4 and medications. According to the primary treating physician's progress report on June 8, 2015, the injured worker continues to experience neck pain and muscle spasm associated with numbness and tingling of the bilateral upper extremities rated at a 5-6 out of 10 on the pain scale. The injured worker also reports elbow and mid back pain rated as 5-6 out of 10. The injured worker has low back pain with muscle spasm associated with numbness and tingling of the bilateral lower extremities rated 6-7 out of 10 on the pain scale. Examination of the cervical spine demonstrated 2 plus tenderness to palpation at the suboccipital region, the trapezius and the sternocleidomastoid muscles. There was decreased active range of motion noted at flexion 25 degrees, extension at 15 degrees, left rotation at 30 degrees, right rotation at 25 degrees, left lateral flexion at 35 degrees and right lateral flexion at 30 degrees with bilateral positive cervical distraction and maximal foraminal compression test. The right elbow examination noted palpable tenderness over the right epicondyle and 2 plus tenderness at the extensor muscle compartment and the ulnar groove with flexion at 60 degrees and pronation and supination at

30 and 35 degrees respectively. Cozen's and cubital Tinel's were positive. Sensation to pinprick and light touch were intact in the bilateral upper extremities with myotomes C5 through T1 decreased due to pain in the bilateral upper extremities. Deep tendon reflexes and pulses were within normal limits. The examination of the thoracic spine demonstrated palpable tenderness over the bilateral thoracic paravertebral muscles and over the spinous processes of T1 through T6. Active range of motion was noted at 25 degrees flexion, left rotation at 35 degrees and right rotation at 25 degrees. Kemp's test was positive and sensation was intact. The lumbar spine evaluation noted an antalgic gait with ability to heel and toe walk with pain exhibited on heel walk. There was hypolordosis noted. There was tenderness to palpation at the lumbar paraspinal muscles bilaterally, posterior superior iliac spine bilaterally and over the spinous processes from L2-S1. Range of motion was documented at 35 degrees flexion, 15 degrees extension, and bilateral lateral flexion at 15 degrees each. Sitting root and straight leg raise were positive bilaterally. Sensation to pinprick and light touch was slightly diminished at L5 and S1 dermatomes in the left lower extremity. Motor strength was decreased bilaterally from L2 through S1. Deep tendon reflexes and pulses were intact in the bilateral lower extremities. Current medications are listed as Tabradol, Synapryn, Cyclobenzaprine, Fanatrex, Dicopanol and Deprizine. Treatment plan consists of consultations with an orthopedic surgeon, psychologist and ENT specialist, continuing with medication regimen and the current request for Extracorporeal Shockwave Therapy (ESWT) once a week for 6 - 12 weeks (6-12 sessions) (Right Elbow x3 sessions, Thoracic, Cervical, Lumbar x6 sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shockwave Therapy (ESWT), 1 time wkly for 6 - 12 weeks (6-12 sessions) - [Right Elbow x3 sessions, Thoracic, Cervical, Lumbar x6 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 598. Decision based on Non-MTUS Citation Official Disability Guidelines: Elbow - Extracorporeal Shockwave Therapy (ESWT); 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, elbow, under shock wave treatment.

Decision rationale: This claimant was injured in 2013 and has diagnoses of cervical spine multi- level disc displacement and degeneration with radiculopathy, right elbow lateral epicondylitis and partial tear of the common extensor tendon, thoracic spine scoliosis, lumbar spine spondylolisthesis, lumbar stenosis and radiculopathy, anxiety and sleep disorder. No surgical interventions were documented. Treatment to date has included diagnostic testing, physical therapy, trigger point impedance imaging and localized intense neurostimulation (LINT) therapy times 6 procedures, extracorporeal shockwave therapy to the thoracic spine times 4 and medications. There is continued pain. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer- reviewed guidelines will be examined. The ODG notes in the Elbow section: Not recommended. High energy ESWT is not supported, but low energy ESWT may show better outcomes without the need for anesthesia, but is still not recommended. Trials in this area have yielded conflicting results. The value, if any, of ESWT for lateral elbow pain, can presently be

neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with heel pain and tennis elbow. However, recent studies do not always support this, and ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects. Given the adverse evidentiary support for the procedure to this region, the request is appropriately not medically necessary.