

<b>Case Number:</b>	CM15-0161784		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	09/01/2011
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	07/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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: California, Hawaii

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 39 year old male, who sustained an industrial injury on 9-1-11. He reported pain in his lower back after opening a container door. The injured worker was diagnosed as having lumbar radiculopathy and lumbar facet arthropathy. Treatment to date has included an EMG-NCV on 7-9-15 showing mild acute L5 radiculopathy on the left, topical medications, Naproxen and Diclofenac. On 4-3-15, the injured worker rated his pain a 3 out of 10 with medications and a 5 out of 10 without medications. On 5-22-15, the injured worker reported chronic pain in the lower back with left radiculopathy. Objective findings include full lumbar range of motion, but painful and positive facet loading. As of the PR2 dated 6-30-15, the treating physician noted light touch sensation to the right mid-anterior thigh, right mid-lateral calf and right lateral ankle are intact. The treating physician requested shockwave therapy once weekly for 6 weeks to the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shockwave 1 time a week for 6 weeks to 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 (ODG), Low Back.

**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, Shockwave Therapy.

**Decision rationale:** The patient presents with pain affecting the low back with radiation down the left lower extremity. The current request is for Shockwave 1 time a week for 6 weeks to lumbar spine. The requesting treating physician report dated 6/30/15 (39B) provides no rationale for the current request. The MTUS guidelines do not address the current request. The ODG guidelines state the following under Shock Wave therapy: "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." In this case, the ODG guidelines do not recommend shockwave therapy for the treatment of low back pain. The current request is not medically necessary.