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| <b>Case Number:</b>   | CM15-0166539 |                              |            |
| <b>Date Assigned:</b> | 09/04/2015   | <b>Date of Injury:</b>       | 05/31/2013 |
| <b>Decision Date:</b> | 10/14/2015   | <b>UR Denial Date:</b>       | 08/03/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/25/2015 |

### 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: Pennsylvania, Ohio, California  
 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 sustained an industrial injury on 05-31-2013. Mechanism of injury occurred while in a freezer. Diagnoses include moderated right and severe left neural foraminal narrowing at L5-S1 with radiculopathy and lumbar sprain-strain. Treatment to date has included diagnostic studies, medications, physical therapy, trigger point injections, home exercises, and activity modification. A physician progress note dated 07-14-2015 documents the injured worker has continued lower back pain with right lower extremity symptoms. She rates her pain as 6 out of 10. There is tenderness of the lumbar spine and lumboparaspinal musculature. She has mild swelling, and straight leg raise is positive at 60 degrees of the right. Range of motion is restricted and painful. There is diminished sensation at right L4 and L5 dermatomal distributions. Her medications allow her to maintain her activities of daily living, and tolerance to activity. The treatment plan includes proceeding with intervention pain management with epidural injections at L5-S1, chiropractic session 3 x a week for 4 weeks, a urine drug screen, and continuation of Duloxetine, Hydrocodone, Naproxen, Pantoprazole, and Cyclobenzaprine. Treatment requested is for Outpatient Shockwave Therapy Five (5) Sessions to the Lumbar Spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Shockwave Therapy Five (5) Sessions to the 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, Low Back, Shockwave Treatment.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

**Decision rationale:** ACOEM does not support shockwave therapy as a recommended treatment modality for the lumbar spine. Other guidelines such as ODG support shockwave in very specific situations to particular body parts such as the heel or elbow but not to the LSPINE. The records do not provide an alternate rationale to support this request. The request is not medically necessary.