

Case Number:	CM15-0181875		
Date Assigned:	09/23/2015	Date of Injury:	08/17/2014
Decision Date:	10/28/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/15/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 an industrial injury on 8-17-2014. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine sprain-strain with IVD, thoracic spine sprain-strain with disc degeneration, sciatica, bilateral shoulder sprain-strain, and radiculitis, myofascitis, and levoconvex thoracic scoliosis. On 7-27-2015, the injured worker reported constant moderate to severe low back pain rated a 5- 9, constant moderate to severe upper back pain rated 5-9, and constant moderate to severe bilateral shoulder pain, all rated on a 1-10 scale. The Primary Treating Physician's report dated 7- 27-2015, noted the injured worker's lumbosacral spine with pain in all planes, and tenderness to palpation over the quadratus lumborum, erector spine, latissimus dorsi, SI joints, gluteus, and biceps femoris bilaterally, with positive Kemps, Bechterews, Elys, and Iliac compression tests bilaterally. The documentation provided noted prior treatments have included physical and manipulative therapy, injections, series of three extracorporeal shockwave treatments in March 2015, May 2015, and a series of four treatments in June 2015, at least 6 sessions of acupuncture, and medications. The treatment plan was noted to include a referral to an orthopedic surgeon for evaluation and treatment, shock wave therapy, a psychological evaluation, continue home stretching and exercises, and Synovacin and Dendracin provided for topical use and joint health. The injured worker was noted to be on modified duty if available, and temporary total disability if unavailable. The request for authorization dated 7-27-2015, requested shockwave therapy 1x4 to the low back-lumbar spine and an ortho surgeon evaluation. The Utilization Review (UR) dated 8-18-2015, modified the request for an ortho surgeon evaluation to certify an ortho consult only, and non-certified the request for shockwave therapy 1x4 to the low back-lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy 1x4 to the low back/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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shockwave therapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the Official Disability Guidelines section on shockwave therapy: Not recommended, particularly using high energy ESWT. It is under study for low energy ESWT. The value, if any, for ESWT treatment of the elbow cannot be confirmed or excluded. Criteria for use of ESWT include: 1. Pain in the lateral elbow despite six months of therapy 2. Three conservative therapies prior to ESWT have been tried prior 3. No contraindications to therapy 4. Maximum of 3 therapy sessions over 3 weeks. The particular service is not recommended for the requested low back complaints per the ODG or the ACOEM. Review of the documentation does not supply information to contradict these recommendations and therefore the request is not medically necessary. In addition ODG guidelines are not met for treatment. Therefore the request is not medically necessary.

Ortho surgeon evaluation: Overturned

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for: 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing low back pain despite treatment by the primary physician. Therefore consult and treatment by an orthopedic specialist is medically necessary.