

<b>Case Number:</b>	CM15-0189843		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	05/27/2015
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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

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 60 year old male, who sustained an industrial injury on 5-27-2015. The injured worker was diagnosed as having lumbar disc protrusion, lumbar muscle spasm, lumbar radiculopathy, and lumbar sprain-strain. Treatment to date has included diagnostics, modified activity, and medications. Currently (8-20-2015), the injured worker complains of continuous low back pain with radiation to the left lower extremity, accompanied with numbness sensation. His pain was rated 10 out of 10. Exam of the lumbar spine noted a moderate antalgic gait and limp, decreased range of motion, strength 4 of 5 in the left extensor hallucis longus and tibialis anterior muscle. There was tenderness to palpation of the lumbar paravertebral muscles and muscle spasm. Straight leg raise was positive on the left. Current medication was noted as "taking medications for pain". Magnetic resonance imaging of the lumbar spine (7-24-2015) showed mild central canal spondylostenosis at L4-L5 on the basis of a degenerative disc bulge and facet arthrosis, moderate severity left foraminal stenosis with impingement of the exiting left L4 nerve root, 2.6mm focal disc protrusion at L5-S1 with no evidence for canal stenosis or foraminal impingement, and multilevel mild degenerative disc changes. His work status was total temporary disability. The requested treatment plan included unspecified extracorporeal shockwave therapy, unspecified trigger points impedance imaging, and unspecified localized intense neurostimulation therapy, non-certified by Utilization Review on 9-04-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Unknown Extracorporeal shockwave therapy: Upheld**

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

**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-Lumbar & Thoracic, under Shockwave Therapy.

**Decision rationale:** The patient was injured on 05/27/15 and presents with lumbar spine pain which radiates to the left lower extremity and has a numbness sensation. The request is for an unknown extracorporeal shockwave therapy. There is no RFA provided and the patient is on temporary total disability. Review of the reports provided does not indicate if the patient had any prior extracorporeal shockwave therapy. ODG Guidelines, Low Back- Lumbar & Thoracic, under Shockwave Therapy states that it is "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." The patient has tenderness to palpation of the lumbar paravertebral muscles, muscle spasm, a positive straight leg raise on the left, and a decreased lumbar spine range of motion. He is diagnosed with lumbar disc protrusion, lumbar muscle spasm, lumbar radiculopathy, and lumbar sprain-strain. Treatment to date has included diagnostics, modified activity, and medications. Treater has not provided reason for the request, nor indicated location to be treated and number of sessions. Nonetheless, guidelines do not support shockwave therapy due to lack of clinical evidence for the effectiveness of this treatment modality. Therefore, the request is not medically necessary.

**Unknown trigger points impedance imaging: 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, Lumbar and Thoracic (Acute and Chronic): Trigger Point Impedance Imaging.

**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 Chapter, under Trigger Point Impedance Imaging.

**Decision rationale:** The patient was injured on 05/27/15 and presents with lumbar spine pain which radiates to the left lower extremity and has a numbness sensation. The request is for an unknown trigger points impedance imaging. There is no RFA provided and the patient is on temporary total disability. Review of the reports provided does not indicate if the patient had a prior trigger point injection. ODG Guidelines, Low Back Chapter, under Trigger Point Impedance Imaging has the following: "Not recommended. See Hyperstimulation analgesia. The Nervomatrix device combines trigger point impedance imaging with hyperstimulation

analgesia... Hyperstimulation Analgesia: Not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer ( [REDACTED] ). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization." The patient has tenderness to palpation of the lumbar paravertebral muscles, muscle spasm, a positive straight leg raise on the left, and a decreased lumbar spine range of motion. He is diagnosed with lumbar disc protrusion, lumbar muscle spasm, lumbar radiculopathy, and lumbar sprain-strain. Treatment to date has included diagnostics, modified activity, and medications. The reason for the request is not provided. The target location of the imaging study is not mentioned. Additionally, the requested imaging technique is not yet supported by guidelines. ODG indicates that there are currently only two low-quality, manufacturer sponsored studies addressing the effectiveness of such imaging techniques. It is not clear why traditional imaging methods are not adequate to identify any underlying pathology in this patient. Given the lack of firm guideline support for the use of such imaging to improve the course of care, the request as written cannot be substantiated. The request is not medically necessary.

**Unknown localized intense neurostimulation therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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- Lumbar & Thoracic, under Hyperstimulation analgesia.

**Decision rationale:** The patient was injured on 05/27/15 and presents with lumbar spine pain which radiates to the left lower extremity and has a numbness sensation. The request is for an unknown localized intense neurostimulation therapy. There is no RFA provided and the patient is on temporary total disability. Review of the reports provided does not indicate if the patient had a prior neurostimulation. ODG guidelines, Low Back- Lumbar & Thoracic, under Hyperstimulation analgesia, states the following: Not recommended until there are higher quality studies. The patient has tenderness to palpation of the lumbar paravertebral muscles, muscle spasm, a positive straight leg raise on the left, and a decreased lumbar spine range of motion. He is diagnosed with lumbar disc protrusion, lumbar muscle spasm, lumbar radiculopathy, and lumbar sprain-strain. Treatment to date has included diagnostics, modified activity, and medications. The reason for the request is not provided. The treater does not explain how this treatment will benefit the patient, and the request does not document the number of sessions as well. Additionally, ODG guidelines do not support neurostimulation due to lack of high quality studies. The request is not medically necessary.