

<b>Case Number:</b>	CM15-0194433		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	10/02/2014
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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 43 year old male who sustained an industrial injury on 10-2-14. The injured worker reported pain in the neck and back. A review of the medical records indicates that the injured worker is undergoing treatments for cervical spine disc bulges, thoracic spine strain and lumbar spine disc rupture. Provider documentation dated 7-15-15 noted the work status as "remain off-work for 8 weeks". Treatment has included Cyclobenzaprine since at least November of 2014, Orphenadrine since at least November of 2014, radiographic studies, and chiropractic treatments. Objective findings dated 7-15-15 were notable for painful range of motion with lumbar paraspinals tenderness. The original utilization review (9-8-15) denied a request for Shockwave therapy 1x wk x 6 wks - Thoracic Spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shockwave therapy 1x/wk x 6 wks - Thoracic 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 - Lumbar & Thoracic (Acute & Chronic) Chapter: 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 and Thoracic) Chapter, under Shock Wave Therapy.

**Decision rationale:** The patient presents on 08/19/15 with neck and back pain. The patient's date of injury is 10/02/14. The request is for Shockwave therapy 1x/wk x 6 wks, Thoracic Spine. The RFA is dated 08/19/15. Physical examination dated 08/19/15 reveals tenderness to palpation of the thoracic and lumbar paraspinal musculature, and reduced range of cervical motion. The patient is currently prescribed Flexeril. Patient's current work status is not provided. Official Disability Guidelines, Low Back (Lumbar and Thoracic) Chapter, under Shock Wave Therapy has the following: 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 regard to the request for a series of 6 extracorporeal shockwave therapy treatments for this patient's ongoing thoracic spine pain, such treatment methods are not supported by guidelines for back pain. There is no indication in the records provided that this patient has undergone any ESWT treatments to date. Official disability guidelines indicate that such procedures are not supported owing to a lack of evidence supporting effectiveness for back complaints. While the provider feels as though this is the best treatment option for this patient, without guideline support for this particular treatment modality the medical necessity cannot be substantiated. The request is not medically necessary.