

<b>Case Number:</b>	CM15-0210520		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	02/16/2015
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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: Emergency Medicine

### 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 worker is a 52 year old female who sustained an industrial injury on February 16, 2015. The worker is being treated for: headache, right wrist strain and sprain, left hip strain and sprain, loss of sleep, and other insomnia. Subjective: August 26, 2015, September 28, 2015, October 08, 2015 she reported head pain rated an "8" intensity without using medication and zero with the use of medications. She also complained of right wrist and left hip pain. She also stated having "difficulty sleeping." Objective: August 26, 2015, September 28, 2015, October 08, 2015 noted the right wrist tender to palpation of the dorsal, lateral, medial and volar wrist. In addition, the left hip noted tender to palpation anterior, lateral and posterior left hip. Diagnostic: MRI lumbar spine September 03, 2015, MRI right wrist August 2015. Medication: July 04, 2015: Tramadol. August 26, 2015, September 28, 2015, and October 08, 2015: dispensed Anaprox, Prilosec, Tramadol, and Cyclobenzaprine along with two topical compound creams. Treatment: medication, wrist brace DME, shockwave therapy, acupuncture session, orthopedic evaluation regarding right wrist. On October 21, 2015 a request was made for shockwave therapy 4 sessions for the hip, thigh and leg that was noncertified by Utilization Review on October 26, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shockwave therapy once a week for 3 weeks to the hip/thigh/knee/leg: 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), Knee and Leg Chapter, ESWT.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic); Shockwave therapy.

**Decision rationale:** The requested Shockwave therapy once a week for 3 weeks to the hip/thigh/knee/leg is not medically necessary. CA MTUS 2009 ACOEM is silent on this issue regarding the knee. ODG Treatment, Integrated Treatment/Disability Duration Guidelines Knee & Leg (Acute & Chronic); Shockwave therapy, noted: "Under study for patellar tendinopathy and for long-bone hypertrophic non-unions. In the first study of this therapy for management of chronic patellar tendinopathy, extracorporeal shockwave therapy seemed to be safer and more effective, with lower recurrence rates, than conventional conservative treatments, according to results of a recent small, randomized controlled trial." The injured worker has right wrist and left hip pain. The treating physician noted the right wrist tenderness to palpation of the dorsal, lateral, medial and volar wrist. In addition, the left hip noted tender to palpation anterior, lateral and posterior left hip. The treating physician has not documented evidence of patellar tendinopathy or any medical necessity for this treatment. The criteria noted above not having been met, Shockwave therapy once a week for 3 weeks to the hip/thigh/knee/leg is not medically necessary.