

<b>Case Number:</b>	CM15-0218552		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	05/07/2015
<b>Decision Date:</b>	12/24/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2015

### 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 60 year old female with a date of injury on 05-07-2015. The injured worker is undergoing treatment for tenosynovitis of the foot-ankle. A physician progress note dated 09-10-2015 documents the injured worker has right hand, left ankle and bilateral foot pain. Her left foot has constant pain and swelling. Her left foot is swollen and is tender to touch with full range of motion. Her right foot has frequent foot and 5th toe pain associated with swelling. She has pain in her right hand. She rated her right foot pain is rated 7 out of 10 and her left foot pain is rated and 8 out of 10. She has tenderness to palpation of the right hand, left and right foot. On 08-17-2015 she fell again in work. X rays were done but were inconclusive. She was instructed on non-weight bearing of the left foot and was instructed in a home exercise program. Additional X ray were ordered and she is pending chiropractic sessions. She is working. Treatment to date has included diagnostic studies, medications, use of a Cam walker, crutches, chiropractic sessions and a home exercise program. She is taking Norco for pain. Magnetic Resonance Imaging of the right foot done on 07-23-2015 revealed transverse fracture at the base of the 5th metatarsal and diffuse subcutaneous edema is noted. Magnetic Resonance Imaging of the left foot done on 07-23-2015 revealed subtalar small joint effusion, posterior tibial tendon, flexor digitorum longus and flexor hallucis longus tenosynovitis, tibiotalar small joint effusion and diffuse subcutaneous edema. The Request for Authorization includes extracorporeal shockwave therapy (frequency and duration unknown) #1 and X rays of the left foot. On 10-08- 2015 Utilization Review non-certified the request for Extracorporeal shockwave therapy (frequency and duration unknown) #1.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Extracorporeal shockwave therapy (frequency and duration unknown) #1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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 certified. In addition ODG guidelines are not met for treatment. Therefore the request is not medically necessary.