

<b>Case Number:</b>	CM15-0082381		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	05/16/2011
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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 55 year old female, who sustained an industrial injury on May 16, 2011. She reported left knee and low back pain. The injured worker was diagnosed as having cervical spine sprain/strain rule out herniated nucleus pulposus (r/o HNP), thoracic spine sprain/strain r/o HNP, lumbar spine sprain/strain r/o HNP, bilateral knee sprain/strain r/o internal derangement, anxiety disorder, mood disorder, sleep disorder and stress. Treatment to date has included diagnostic studies, acupuncture, conservative care, medications and work restrictions. Currently, the injured worker complains of neck pain with associated bilateral upper extremity burning and tingling, mid and low back pain bilateral knee pain with associated bilateral lower extremity burning and tingling and depression and anxiety. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on November 11, 2014, revealed continued pain and frustration. Shockwave therapy for the lumbar spine and left knee was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shockwave Therapy for the left knee Qty 3: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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. Criteria for therapy have not been met and the request is not medically necessary.

### **Shockwave Therapy for the Lumbar Spine Qty 6: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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. Criteria for this service have not been met and the request is not medically necessary.