

Case Number:	CM14-0133206		
Date Assigned:	08/22/2014	Date of Injury:	03/02/2011
Decision Date:	09/24/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/20/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49-year-old female with a date of injury of 3/2/11. The mechanism of injury occurred when she slipped and fell down a flight of stairs. On 4/1/14, it was noted that the patient was prescribed Deprizine (ranitidine and other proprietary ingredients), Dicopanol (Diphenhydramine and other proprietary ingredients), Fanatrex (Gabapentin and other proprietary ingredients), Synapryn (Tramadol and Glucosamine and other proprietary ingredients), Tabradol (Cyclobenzaprine, Methylsulfonylmethane and other proprietary ingredients), Cyclophene (Cyclobenzaprine and other proprietary ingredients), and Ketoprofen cream. On 6/17/14, she complained to headaches, burning radicular neck, low back, mid back, and bilateral hip pain. This pain radiated to the bilateral upper and lower extremities with numbness and tingling. The pain was rated 5-6/10. On exam the cervical spine was tender with decrease range of motion and decreased sensation. The thoracic spine was tender with decreased range of motion. The lumbar paraspinals were tender to palpation and decreased range of motion. The bilateral hips were tender also with decreased range of motion. The diagnostic impression is sleep disorder, cervical disc displacement (HNP), stress, anxiety, headaches, cephalgia, thoracic spine strain/sprain and radiculitis of the lower extremity. Treatment to date includes acupuncture, physical therapy, chiropractic therapy, MRI, activity management, and medication management. A UR decision dated 8/5/14 denied the request for extracorporeal shockwave therapy (ESWT) for the spine. The rationale and scientific basis for this application are not provided and national guidelines do not apply. A literature search failed to reveal peer reviewed quality supportive scientific studies that establish efficacy for improved pain management and increased activities of daily living (ADL) functioning and decreased pain medication use compared with standard care. The MD should provide peer reviewed scientific studies to demonstrate the greater benefit of ESWT use over

standard care in such cases as this to enhance functional improvement and improve pain management and establish medical necessity for use of this modality for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy one time a week for six to twelve weeks for the cervical/thoracic/lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 598. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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, Shock Wave Therapy.

Decision rationale: The California MTUS does not address this issue. The Official Disability Guidelines states that shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The requesting physician failed to establish compelling circumstances identifying why ESWT for the low back unit be required despite adverse evidence. Recommend non-certification. However, it was noted on 4/1/14, the patient was prescribed 7 different medications, all of which are compounded medications and all are not supported by guidelines. It is unclear what benefit the patient is receiving from these medications. The guidelines do not support the use of ESWT for the low back for chronic pain. A specific rationale identifying why ESWT would be required in this patient despite lack of guideline support was not identified. Therefore, the request for Extracorporeal Shockwave Therapy one time a week for six weeks is not medically necessary.