

<b>Case Number:</b>	CM14-0161730		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	08/28/2009
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Internal Medicine 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:

The physician progress report dated August 12, 2014 stated that the injured worker was status post left knee arthroscopy times 3 weeks ago. The injured worker complained of swelling to the left leg. His medications include Coumadin 12mg, and Cozaar 10mg. The case notes stated that the injured worker was seen on September 10, 2014 with complaints of low back pain that radiated down the bilateral lower extremities with associated symptoms of weakness. The injured worker also revealed tenderness to the left foot with decreased range of motion. He also complains of left foot pain, knee pain with aching and swelling on the left leg to the left foot. On examination, there is tenderness on the left foot, and decreased range of motion. Tenderness to lumbar spine with decreased range of motion and spasm and tenderness to the left knee with decreased range of motion was noted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ortho Shockwave for 6 Sessions for Lumbar Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, 11th Edition (web), 2013, Low Back, Shockwave 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 Chapter, Shock Wave Therapy, 2014 Edition

**Decision rationale:** The Official Disability Guidelines (ODG), Low Back, Shock Wave Therapy, 2014 Edition states shockwave therapy is not medically necessary. The California MTUS, Chronic Pain Treatment Guidelines do not address the request for shockwave treatment pain. The Official Disability Guidelines (ODG) state shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not medically necessary. Based on clinical information in the medical records and the evidence-based peer-reviewed guidelines, shockwave therapy is not medically necessary.