

<b>Case Number:</b>	CM15-0110015		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	06/03/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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 46 year old male injured worker suffered an industrial injury on 06/03/2014. The diagnoses included cervical dis protrusion, myofascitis, sprain/strain, with degeneration of the cervical intervertebral disc, lumbar myofascitis and sprain/strain, left shoulder sprain/strain, and left carpal tunnel syndrome. The diagnostics included electromyographic studies/nerve conduction velocity studies. The injured worker had been treated with medications. On 3/7/2015 the treating provider reported the cervical and lumbar spine had moderate pain 5/10 with pain and stiffness. The lumbar epidural steroid injections provided relief. The left shoulder and wrist had intermittent pain 5/10 with stiffness. The injured worker also suffered from depression and anxiety. On exam the lumbar spine had reduced range of motion. The treatment plan included Orthopedic Surgeon referral, Pain Management referral, and Extracorporeal Shock Wave Therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orthopedic Surgeon referral:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement Page(s): 8-9.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM, the health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of ongoing back pain that have failed treatment by the primary treating physician. Therefore criteria for an orthopedic consult have been met and the request is certified.

**Pain Management referral:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement Page(s): 8-9.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM, the health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of ongoing pain that have failed treatment by the primary treating physician. Therefore criteria for a pain management consult have been met and the request is certified.

**Extracorporeal Shock Wave Therapy (ESWT) for Left Wrist, Qty 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement Page(s): 8-9.

**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 and 4. Maximum of 3 therapy sessions over 3 weeks. Neither the ODG nor ACOEM recommend shockwave therapy for the wrist. Criteria as outlined above have not been met and therefore the request is not certified.