

Case Number:	CM15-0116079		
Date Assigned:	06/24/2015	Date of Injury:	09/01/1993
Decision Date:	07/24/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/16/2015

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: California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 44 year old female, who sustained an industrial/work injury on 9/1/93. She reported initial complaints of low back and hip pain. The injured worker was diagnosed as having lumbar spine pain, myofascial pain syndrome, right sided iliac crest pain, and possible thoracic outlet syndrome. Treatment to date has included medication, physical therapy, and diagnostic testing. Electromyography and nerve conduction velocity test (EMG/NCV) was performed on 1/13/11 was normal. Currently, the injured worker complains of chronic low back pain. Per the primary physician's progress report (PR-2) on 5/12/15, examination noted light touch sensation to right mid-anterior thigh, right mid lateral calf, right lateral ankle are intact. The requested treatments include 8 shockwave therapy sessions for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 shockwave therapy sessions for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 203; 371. Decision based on Non-MTUS Citation 1) Bannuru, RR; Flavin, NE; Vaysbrot, E; Harvey, W; McAlindon, T. High-energy extracorporeal shock-wave therapy for treating chronic calcific tendinitis of the shoulder: a

systematic review. *Ann Intern Med.* 2014 Apr 15;160 (8): 542-9.2) Mouzopoulos G1, Stamatakos M, Mouzopoulos D, Tzurbakis M. Extracorporeal shock wave treatment for shoulder calcific tendonitis: a systematic review. *Skeletal Radiol.* 2007 Sep; 36(9): 803-11. Epub 2007 Apr 6.3) American Academy of Orthopaedic Surgeons. Optimizing Management of Rotator Cuff Problems: Guideline and Evidence Report. Dec 2010.

Decision rationale: Extracorporeal shockwave therapy (ESWT) is a method of treatment for multiple tendonopathies. Although its medical value is disputed, there are a growing number of random controlled studies showing its effectiveness for treating chronic calcific tendinitis of the shoulder, plantar fasciitis and tennis elbow. ESWT is also commonly used for treating orthopedic problems in horses, including tendon and ligament injuries, kissing spine, navicular syndrome, and arthritis. It is thought to work by a repeated shock wave creating microtrauma thus stimulating neo-vascularization (new blood flow) into the area treated. This new blood flow promotes tissue healing. The ACOEM guidelines suggest it as a treatment option for treating calcific tendinitis of the shoulder and plantar fasciitis. This patient has not been diagnosed as having either calcific tendonitis of the shoulder or plantar fasciitis. There is no guideline promoting its use for lower back diagnoses. Medical necessity for use of this treatment modality has not been established. The request is not medically necessary.