

<b>Case Number:</b>	CM15-0124294		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	06/14/2012
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2015

### 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 33 year old male, who sustained an industrial injury on 6/14/12. Initial complaints were not reviewed. The injured worker was diagnosed as having lumbar disc protrusion L4-5 and L5-S1 with radiculopathy. Treatment to date has included status post lumbar decompression (1/2015); physical therapy; medications. Currently, the PR-2 notes dated 4/8/15 indicated the injured worker is a status post left lumbar decompression of January 2015. She reports back pain with right greater than the left lower extremity symptoms rated at 5/10. She has had 12 sessions of postoperative physical therapy which have diminished pain and improved range of motion. She recalls a successful trail of topical antiepileptic drugs that decreased her pain and lumbar radicular component improving tolerance to standing and walking 30% of the time. She recalls that the oral antiepileptic drugs failed due to causing nausea and lethargy. She failed the antidepressant in this regard as well. Objective findings note tenderness to the lumbar spine. Lumbar range of motion percent of normal: flexion 50, extension 40, left and right lateral tilt 40, positive straight leg raise with left for pain in foot and right pain to distal calf at 45 degrees. She has spasms in the lumboparaspinal musculature less pronounced. The provider is requesting authorization of extracorporeal shock wave therapy for 5 sessions for the low back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Extracorporeal shock wave therapy for 5 sessions for the low back: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Shock wave therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (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. The ACOEM low back chapter does not recommend this as a treatment modality. The request does not meet ODG guidelines. Therefore the request is not medically necessary.