

<b>Case Number:</b>	CM15-0094424		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	09/03/2007
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: Connecticut, California, Virginia  
 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 51-year-old male, who sustained an industrial injury on September 3, 2007. Treatment to date has included right shoulder surgery, physical therapy, acupuncture therapy and medications. Currently, the injured worker complains of constant moderate achy low back pain, right shoulder pain, left knee pain and left ankle pain and stiffness. On physical examination, the injured worker has 5+/5 motor strength in the bilateral upper and lower extremities. His range of motion was limited in the lumbar spine, the right shoulder and the left knee and ankle. The diagnoses associated with the request include lumbar myofascitis, right shoulder bursitis, left knee chondromalacia, left knee internal derangement, and left ankle sprain/strain. The treatment plan includes medications. A request was received for trigger point impendence imaging, referral to a podiatrist, localized intense Neurostimulation therapy and extracorporeal shockwave therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 trigger point impedance imaging, TPII: 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 - Lumbar & Thoracic (Acute & Chronic), Trigger point impedance imaging.

**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 Trigger point impedance imaging.

**Decision rationale:** The MTUS does not address the use of trigger point impedance imaging, and therefore the ODG provides the preferred mechanism for assessment of clinical necessity in this case. The ODG does not recommend trigger point impedance imaging at this time due to lack of substantial evidence. Trigger point impedance imaging in this case, therefore, cannot be considered medically necessary at this time.

**1 localized intense neurostimulation therapy, LINT: 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 - Lumbar & Thoracic (Acute & Chronic), Hyperstimulation analgesia.

**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, hyperstimulation analgesia.

**Decision rationale:** The MTUS does not address the use of localized intense neurostimulation therapy, and therefore the ODG provides the preferred mechanism for assessment of clinical necessity in this case. The ODG does not recommend this procedure at this time due to lack of substantial evidence. According to the ODG, hyper stimulation analgesia is not recommended until there are higher quality studies available to support the clinical value in treatment. Therefore, in this case, the requested procedure is not supported by the evidence and cannot, therefore, be considered medically necessary.

**1 extracorporeal shockwave therapy visits, ESWT: 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 - Lumbar & Thoracic (Acute & Chronic), 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) low back, ultrasound, therapeutic.

**Decision rationale:** Extracorporeal shockwave therapy is not recommended by the guidelines based on medical evidence, which shows that there is no proven efficacy. Specifically, the available evidence does not support the effectiveness of shockwave therapy for treating low back pain. In the absence of such evidence, the use of this treatment should be discouraged, and therefore, the request cannot be considered medically necessary.