

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/4/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/13/2013
Date of Injury:	3/23/2010
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017631

- 1) MAXIMUS Federal Services, Inc. has determined the request for **shockwave therapy of lumbar spine x 6 sessions is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/13/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **shockwave therapy of lumbar spine x 6 sessions** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management: 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This patient is a 36-year-old with a date of injury of 3/23/2010. A Panel Qualified Medical Examination in Psychiatry dated 7/26/2013, identifies that the mechanism of injury was falling from a roof. A progress report by [REDACTED], dated 4/8/13 identifies subjective complaints, including "intermittent low back pain as 6/10 radiating into the left lower extremity." Objective findings identify decreased lumbar range of motion, negative orthopedic testing, and normal sensory and motor exam. Diagnoses related to the lower back indicate that the patient is status post lumbar fusion and has a sacrococcygeal contusion. Treatment plan at that time recommended continuing with a home exercise program and continuing with medications. A utilization Review determination was rendered on 8/13/2013 recommending non-certification of "shockwave therapy of lumbar spine x 6 sessions". A medical report dated 8/23/2013 by [REDACTED] states that the patient "underwent conservative care to the low back including but not limited to medications, physical and manipulating therapy, injections and still has significant residual symptoms." The note goes on to recommend extracorporeal shockwave therapy by the treating physician.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

[REDACTED]

1) Regarding the request for shockwave therapy of lumbar spine x 6 sessions:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Low Back, which is not part of the MTUS

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG) Low Back Chapter: Shock wave therapy, which is not part of the MTUS.

Rationale for the Decision:

The current request is for shockwave therapy for the lumbar spine. California MTUS guidelines and ACOEM guidelines are silent with regards to the use of shockwave therapy in the treatment of lumbar spine disorders. ODG guidelines state that shockwave therapy is not recommended in the treatment of the lumbar spine. They state that such treatment is not justified and should be discouraged. As such, the current request for shockwave therapy for the lumbar spine is not medically necessary. **The request for shockwave therapy of lumbar spine x 6 sessions is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations



/dat

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.