

Case Number:	CM13-0049238		
Date Assigned:	04/07/2014	Date of Injury:	07/11/2013
Decision Date:	05/23/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/07/2013

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. The expert reviewer is Board Certified in Occupational Medicine 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 applicant is a represented [REDACTED] employee who has filed a claim for knee and leg pain reportedly associated with an industrial injury of July 11, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; unspecified amounts of physical therapy and acupuncture; attorney representation; and a cane. In a Utilization Review a clinical progress note of September 6, 2013 was notable for comments that the applicant was given a diagnosis of knee and leg pain. The applicant had x-rays demonstrating severe hip degenerative joint disease. Motrin, Tylenol, a knee support, and an ice pack were prescribed while the applicant was returned to regular work. On November 27, 2013, it appears that the applicant transferred care to a new primary treating provider and was placed off of work. On September 18, 2013, the applicant presented with moderate-to-severe low back, left leg, knee, and mid back pain. Chiropractic manipulative therapy and extracorporeal shock wave therapy were seemingly endorsed.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 US National Library of Medicine, National Institute of Health article.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 12 Low Back Complaints Page(s): 300,339.

Decision rationale: The documentation on file does not clearly establish what precisely this request represents. It does, however, seemingly represent a form of electrical stimulation therapy. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 300, and the MTUS-adopted ACOEM Guidelines in Chapter 13, page 339, TENS units have insufficient evidence of benefit in treating acute knee and/or low back issues, as are present here. No compelling case for a variance from the ACOEM Guidelines has been made. Therefore, the request remains not medically necessary.

A FUNCTIONAL CAPACITY EVALUATION: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 2, page 21, functional capacity evaluations can be considered when necessary to translate medical impairment into functional limitations and to determine work capability. In this case, however, the reporting of the applicant's work status has not been clearly stated. On some visits, it was suggested that the applicant had been returned to work, effectively obviating the need for functional capacity testing. In this case, again, no clear rationale for the test in question was provided. Therefore, the request is not medically necessary.

SHOCKWAVE THERAPY: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 300,339.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 13, page 339, and the MTUS-adopted ACOEM Guidelines in Chapter 12, page 300, physical modalities such as ultrasound have no scientifically proven efficacy in treating acute knee or low back pain issues. Again, extracorporeal shock wave therapy represents a form of ultrasound therapy. However, ultrasound is not recommended for acute low back or knee pain, per ACOEM. It is further noted that the Third Edition ACOEM Guidelines suggests that there is evidence that for most body parts, that extracorporeal shock wave therapy is ineffective. In this case, again, the attending provider did not furnish any applicant-specific rationale, narrative, or commentary along with the request for authorization which would offset the unfavorable ACOEM recommendations. The request is not medically necessary.