

Case Number:	CM14-0018592		
Date Assigned:	04/18/2014	Date of Injury:	04/25/2011
Decision Date:	06/30/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/13/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 injured worker is a 30-year-old male who reported an injury on 04/25/2011 after a slip and fall. The injured worker reportedly sustained an injury to his lumbar, thoracic, and cervical spine and right leg. The injured worker's treatment history included physical therapy, medications, TENS unit, shockwave therapy, epidural steroid injections, facet injections, and acupuncture. The injured worker underwent a Functional Capacity Evaluation on 05/22/2013. This evaluation concluded that the injured worker had deficits that limited her ability to perform her normal job duties. It was noted that he injured worker may benefit from vocational training. The injured worker was evaluated on 11/22/2013. It was documented that the injured worker had cervical spine, thoracic spine and lumbar spine pain rated at a 5/10 to 6/10. Physical findings included 2+ tenderness to the cervical paraspinal musculature with decreased range of motion and a positive bilateral foraminal compression test. Evaluation of the thoracic spine documented tenderness over the T4 through T6 spinous process. Evaluation of the lumbar spine documented decreased range of motion secondary to pain with tenderness to palpation of the paraspinal musculature and a positive straight leg raising test bilaterally with diminished sensation and motor strength at the bilateral lower extremities. The injured worker's diagnoses included cervical spine sprain/strain, cervical radiculopathy, thoracic spine/strain, lumbar spine herniated disc, and lumbar radiculopathy. The injured worker's treatment plan included a Functional Capacity Evaluation and shockwave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 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), Pain (Chronic), Functional Capacity Evaluations (FCEs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 5, 77-89.

Decision rationale: The requested Functional Capacity Evaluation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend Functional Capacity Evaluations when a more precise delineation of the injured worker's functional capabilities is required above what can be provided during a traditional physical exam. The clinical documentation submitted for review does indicate that the injured worker underwent a Functional Capacity Evaluation in 05/2013. The clinical documentation did not provide a significant change in the injured worker's clinical presentation to support that an additional Functional Capacity Evaluation would provide significantly different results. Additionally, the clinical documentation does not provide any evidence that the injured worker is at or near maximum medical improvement. Therefore, the need for a Functional Capacity Evaluation is not clearly indicated within the documentation. As such, the requested Functional Capacity Evaluation is not medically necessary or appropriate.

6 SHOCKWAVE THERAPY VISITS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Seco, J., Kovacs, F. M., & Urrutia, G. (2011). The efficacy, safety, effectiveness, and cost-effectiveness of ultrasound and shock wave therapies for low back pain: a systematic review. *The Spine Journal*, 11(10), 966-977. Kawchuk, G. N. (2011). Commentary: therapeutic ultrasound: what now?. *The Spine Journal*, 11(10), 978.

Decision rationale: The requested six shockwave therapy visits are not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has a history of shockwave therapy for medical treatment of the low back. The California Medical Treatment Utilization Schedule does not address this type of treatment modality. The Official Disability Guidelines do not address shockwave therapy for the neck and upper back or low back. Peer reviewed literature does support the use of shockwave therapy for the low back. However, the clinical documentation submitted for review does indicate that the injured worker has previously undergone shockwave therapy and did not receive significant results. Additionally, it is noted within the documentation that the previous shockwave therapy increased the injured worker's pain. Therefore, additional shockwave treatments would not be supported.

