

Case Number:	CM14-0150045		
Date Assigned:	09/18/2014	Date of Injury:	05/03/2012
Decision Date:	10/17/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/15/2014

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 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:

This is a 45 year old male with a 5/3/2012 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 7/17/14 noted subjective complaints of burning radicular low back pain with numbness in bilateral legs, right knee pain, and left ankle/foot pain. Objective findings included decreased left lower extremity motor strength and sensation, left ankle decreased ROM. There was right knee lateral joint line tenderness, decreased ROM, positive McMurray's and Lachman's. Right knee MRI dated 12/3/13 showed meniscal tear, partial ACL tear, LCL complex sprain. Diagnostic Impression: lumbar radiculopathy, left ankle sprain, right knee ACL tear, right knee joint effusion. Treatment to Date: medication management, LINT. A UR decision dated 8/19/14 denied the request for MRI of the right knee. There is no documentation suggesting surgical consideration of the right knee and no evidence of progression of symptoms to warrant repeat study. It also denied shockwave therapy sessions for the lumbar spine, bilateral knees and left ankle/foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 335-336. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee and leg chapter

Decision rationale: CA MTUS recommends MRI for an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, clear signs of a bucket handle tear, or to determine extent of ACL tear preoperatively. In addition, ODG criteria include acute trauma to the knee, significant trauma, suspect posterior knee dislocation; nontraumatic knee pain and initial plain radiographs either nondiagnostic or suggesting internal derangement. However, in the documents available for review, there is no mention of surgical consideration for the right knee. There is no mention of interval injury to the knee since initial MRI 12/13. It is unclear how a repeat MRI would be of benefit. Therefore, the request for MRI of the right knee was not medically necessary.

Shockwave therapy sessions for the lumbar spine, bilateral knees and left ankle/foot:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines); Knee & Leg (Acute & Chronic)

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 chapter

Decision rationale: CA MTUS does not address this issue. ODG states that shockwave Therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The requesting physician failed to establish compelling circumstances identifying why ESWT for the low back would be required despite adverse evidence. Regarding the knee, ODG states that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. There is no diagnosis of patellar tendinopathy, and no available evidence to support the use of shock wave therapy in other knee conditions. Regarding the foot/ankle, ODG criteria for low energy ESWT include patients whose heel pain from plantar fasciitis has remained despite six months of standard treatment; at least three conservative treatments have been performed prior to use of ESWT. However, the patient does not carry a diagnosis of plantar fasciitis. Therefore, the request for shockwave therapy sessions for the lumbar spine, bilateral knees and left ankle/foot was not medically necessary.