

Case Number:	CM14-0169444		
Date Assigned:	10/17/2014	Date of Injury:	12/08/2013
Decision Date:	12/02/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/14/2014

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 Family 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 63 years old female patient who sustained an injury on 12/8/13. She sustained the injury due to involvement in work related accident. The current diagnoses include low back pain, lumbar spine sprain or strain, radiculitis, lower extremity, lumbar spine degenerative disc disease, lumbar disc displacement herniated nucleus pulposus (HNP), right knee sprain/ strain, right knee lateral meniscal tear, right knee internal derangement, right knee Baker's cyst and right foot osteoarthritis. Per the doctor's note dated 7/29/14, she had complaints of low back pain with tingling and numbness in bilateral lower extremities, right knee pain and right foot pain. Physical examination revealed lumbar spine- tenderness, decreased range of motion and negative straight leg raising test; right knee- tenderness to medial and lateral joint line and patellofemoral joint, range of motion: flexion 120 and extension 0 degree; right foot- tenderness to palpation at distal aspect of the right foot and tenderness at the calcaneus; slight decreased sensation in L4, L5 and S1 dermatomes on the right side; 4/5 strength in bilateral lower extremities and 2 + deep tendon reflexes bilaterally. The medications list includes Tabradol, Cyclobenzaprine, Ketoprofen cream, Deprizine, Dicopanol, Fanatrex and Synapryn. She has had chiropractic visits and acupuncture visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy 3 treatments for right knee and foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation ODG Ankle & Foot (updated 07/29/14) Extracorporeal shock wave therapy (ESWT) Criteria for the use of Extracorporeal Shock Wave Therapy (ESWT) ODG Knee & Leg (updated 08/25/14) Extracorporeal shock wave therapy (ESWT)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Chapter: Ankle & Foot (updated 10/29/14) Extracorporeal shock wave therapy (ESWT) Chapter: Knee & Leg (updated 10/27/14) Extracorporeal shock wave therapy (ESWT)

Decision rationale: Per the ODG cited above shockwave treatment is "Not recommended using high energy ESWT. Recommended using low energy ESWT as an option for chronic plantar fasciitis, where the latest studies show better outcomes without the need for anesthesia." In addition per the ODG cited above "Under study for patellar tendinopathy and for long-bone hypertrophic nonunions." Per the cited guidelines there is no high grade scientific evidence to support the use of shockwave treatment for this diagnosis. Evidence of plantar fasciitis is not specified in the records provided. Evidence of patellar tendinopathy and long-bone hypertrophic nonunions is not specified in the records provided. The medical necessity of Shockwave therapy 3 treatments for the right knee and foot is not fully established for this patient.

Shockwave therapy 6 treatments for lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 08/22/14); 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); Chapter: Low Back (updated 10/28/14) Shock wave therapy

Decision rationale: Per the ODG cited below shockwave treatment 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. (Seco, 2011)." Per the cited guidelines there is no high grade scientific evidence to support the use of shockwave treatment for this diagnosis. The medical necessity of Shockwave therapy 6 treatments for lumbar spine is not fully established for this patient.