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| Case Number: | CM14-0036356 | | |
| Date Assigned: | 06/25/2014 | Date of Injury: | 04/26/2005 |
| Decision Date: | 07/25/2014 | UR Denial Date: | 02/17/2014 |
| Priority: | Standard | Application Received: | 03/25/2014 |

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 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 injured worker is a 52-year-old female with a reported date of injury on 04/26/2005. The mechanism of injury was reported as occurring while lifting a box approximately 66 pounds. The injured worker presented with right knee pain, rated at 6/10. Upon clinical examination, the right knee presented with swelling and limited range of motion. The MRI of the right knee dated 12/18/2013 revealed osteoarthritic changes. Previous physical therapy and conservative care was not provided within the documentation available for review. The injured worker's left knee range of motion revealed flexion to 150 degrees. The injured worker's diagnoses included bilateral wrist carpal tunnel syndrome, right knee internal derangement (history of surgery x 2), left knee musculoligamentous injury, and cervical spine musculoligamentous injury. The injured worker's medication regimen included Ultram, Flexeril, naproxen, Prilosec, Flurbiprofen cream, and Gabacyclotram topical analgesic. The request for authorization form for shockwave therapy right knee x 3 was submitted on 02/24/2014. The physician indicated that due to the injured worker's subjective complaints and objective findings, shockwave therapy was requested for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Three (3) Shockwave therapy sessions for right knee: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Upper Leg, Extracorporeal Shock Wave Therapy.

Decision rationale: The Official Disability Guidelines state that extracorporeal shockwave therapy is under study for patellar tendinopathy and for long bone hypertrophic nonunions. According to the clinical documentation provided for review, the injured worker does not have a diagnosis of patellar tendinopathy. There is a lack of documentation related to the injured worker's objective clinical findings of functional deficits. In addition, the request as submitted failed to provide the number of shockwaves used, energy levels applied, and frequency of application. Therefore, the request for three (3) Shockwave therapy sessions for right knee is not medically necessary and appropriate.