

<b>Case Number:</b>	CM14-0052271		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	03/23/2000
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck pain, chronic low back pain, and multifocal joint pain reportedly associated with an industrial injury of March 23, 2000. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; earlier lumbar fusion surgery; subsequent laminectomy surgery; adjuvant medication; and right knee arthroscopy. In a Utilization Review Report dated April 9, 2014, the claims administrator retrospectively denied a motorized IC unit, extracorporeal shockwave therapy, and a pool installation. A hip corticosteroid injection, conversely, was approved. The applicant's attorney subsequently appealed. In a January 7, 2014 progress note, the applicant presented with 4-10/10 pain. The applicant is asked to continue home exercise, Cymbalta, Colace, Percocet, Exoten lotion, vitamin D, BuTrans, and Flector were endorsed. The applicant's work status was not provided. In a January 3, 2014 primary treating provider note, the applicant was given a lumbar pillow and an interferential stimulator device. Permanent work restrictions were endorsed. The applicant was given trigger point injection into the left Iliac crest region comprising of Lidocaine and Celestone, it was incidentally noted. It appeared that the applicant was later contemplating gastric bypass surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motorized ice unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** While the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-5, page 299 does endorse at-home local applications of heat and cold as methods of symptom control for low back complaints, ACOEM does not, by implication, endorse the motorized IC unit, high-tech means of delivering cryotherapy. No compelling case was made for provision of the motorized IC unit in the face of the unfavorable ACOEM recommendation. Therefore, the request for Motorized ice unit is not medically necessary.

**Extracorporeal shockwave therapy to the right trochanteric area of the right hip:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Knee and Leg Chapter, Extracorporeal shockwave therapy (ESWT).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines . MTUS page 123, Therapeutic Ultrasound topic Page(s): 123.

**Decision rationale:** Extracorporeal shockwave therapy is a form of therapeutic ultrasound. However, as noted on page 123 of the MTUS Chronic Pain Medical Treatment Guidelines, therapeutic ultrasound is not recommended. There is little evidence of therapeutic ultrasound is more effective than placebo, the MTUS notes. It is further noted that the third edition ACOEM Guidelines suggest that for most body parts, there is evidence that extracorporeal shockwave therapy is ineffectual. As with the preceding request, no applicant-specific rationale or medical evidence is furnished so as to offset the unfavorable MTUS and ACOEM recommendations. It is further noted that there appears to be considerable lack of diagnostic clarity here. The applicant has been given a variety of operating diagnoses, including chronic low back pain, sacroiliac joint pain, and knee pain. Therefore, the request for Extracorporeal shockwave therapy to the right trochanteric area of the right hip is not medically necessary.

**Current pool installation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 5, page 83, to achieve functional recovery, applicants must assume certain responsibilities, one of which includes adhering to and maintaining exercise regimens. Thus, the pool being sought here, per

ACOEM, represents an article of applicant responsibility as opposed to a matter of payor responsibility. Accordingly, the request for Current pool installation is not medically necessary.