

Case Number:	CM14-0206414		
Date Assigned:	12/18/2014	Date of Injury:	05/13/2014
Decision Date:	04/24/2015	UR Denial Date:	11/24/2014
Priority:	Standard	Application Received:	12/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

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 64 year old woman sustained an industrial injury on 5/13/2014. The mechanism of injury is not detailed. Current diagnoses include chest wall contusion and derangement of knee. Treatment has included oral medications. Physician notes dated 10/15/2014 show shockwave therapy notes. A total number of 2300 shocks were delivered without interruption to trigger points 1, 2, and 3 to the left knee. On 11/24/2014, Utilization Review evaluated a retrospective prescription for three sessions of shockwave therapy for the left knee that was submitted on 12/4/2014. The UR physician noted that worker was released to modified duty, however, was not able to work while taking narcotics for pain relief. Further, there was no documentation submitted with a rationale for this service. The MTUS, ACOEM Guidelines, (or ODG) was cited. The request was denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective shockwave therapy for the left knee x 3: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 346-347.

Decision rationale: This 64 year old female has complained of left knee pain and chest wall pain since date of injury 5/13/14. She has been treated with shock wave therapy, physical therapy, TENS unit and medications. The current request is for retrospective shockwave therapy for the left knee x 3. Per the ACOEM guidelines cited above, shockwave therapy for the knee is not a recommended therapeutic intervention. On the basis of the available medical records and per the ACOEM guidelines cited above, retrospective shockwave therapy for the left knee is not indicated as medically necessary.

Retrospective functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations, page 132-139.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 346-347.

Decision rationale: This 64 year old female has complained of left knee pain and chest wall pain since date of injury 5/13/14. She has been treated with shock wave therapy, physical therapy, TENS unit and medications. The current request is for a retrospective functional capacity evaluation. Per the MTUS guidelines cited above, a functional capacity evaluation is not recommended in the evaluation and treatment of knee pain. Further, there is no provider documentation discussing the rationale for the medical necessity of a functional capacity evaluation at this time. On the basis of this lack of documentation and the cited ACOEM guidelines, a functional capacity evaluation is not indicated as medically necessary.

Retrospective physical therapy 2 x 4 to the chest wall and left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: This 64 year old female has complained of left knee pain and chest wall pain since date of injury 5/13/14. She has been treated with shock wave therapy, physical therapy, TENS unit and medications. The current request is for physical therapy 2 x 4 chest wall/ left knee. Per the MTUS recommendations cited above, 8-10 passive (out of home) visits over the course of 4 weeks are indicated for a diagnosis of neuralgia, myalgia or radiculitis. The medical necessity for continuation of passive physical therapy is not documented. As supported by the provided documentation, the claimant should, at this point, be able to continue active (self) home therapy. The request for physical therapy 2 x 4 chest wall/ left knee is therefore not indicated as medically necessary.

Retrospective physical therapy 2 x 4 to the left knee/chest: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: This 64 year old female has complained of left knee pain and chest wall pain since date of injury 5/13/14. She has been treated with shock wave therapy, physical therapy, TENS unit and medications. The current request is for physical therapy 2 x 4 left knee / chest wall. Per the MTUS recommendations cited above, 8-10 passive (out of home) visits over the course of 4 weeks are indicated for a diagnosis of neuralgia, myalgia or radiculitis. The medical necessity for continuation of passive physical therapy is not documented. As supported by the provided documentation, the claimant should, at this point, be able to continue active (self) home therapy. The request for physical therapy 2 x 4 left knee/chest wall is therefore not indicated as medically necessary.