

<b>Case Number:</b>	CM14-0061157		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	11/09/2011
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	04/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2014

### 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: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 57 year old male, who sustained an industrial injury on 11/9/11. The injured worker was diagnosed as having cervical spine disc bulges, thoracic spine strain, lumbar spine disc bulge, right elbow strain, left elbow strain, status post left knee surgery and left ankle/foot strain, cephalgia. Treatment to date has included left knee surgery, Synvisc injections to left knee, physical therapy, oral medications and home exercise program. Currently, the injured worker complains of tolerable low back pain. Upon physical exam, light touch sensation of right mid-anterior thigh, right mild-lateral calf and right lateral ankle are noted to be intact. The treatment plan included shockwave therapy, gym membership and lint therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Shockwave Therapy Sessions, 1 x per week for 6 weeks, for the Thoracic Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 03/18/2014 - 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) Low Back Section, Shockwave Therapy.

**Decision rationale:** Pursuant to the Official Disability Guidelines, shockwave therapy one time per week times six weeks to the thoracic spine is not medically necessary. Shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound shockwave therapy for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. In this case, the injured workers working diagnoses are cervical spine disc bulges; thoracic spine strain; lumbar disc bulges; right elbow strain; left elbow strain; status post left knee surgery; left ankle/foot sprain; and cephalgia. The guidelines do not recommend shockwave therapy to the lumbar spine. There are no subjective complaints or objective clinical findings referable to the thoracic spine. There is no documentation regarding prior conservative measures referable to the thoracic spine. Consequently, absent clinical documentation with conservative measures applicable to the thoracic spine with guidelines non-recommendations for shockwave therapy to the lumbar spine, shockwave therapy one time per week times six weeks to the thoracic spine is not medically necessary.

**Aqua Therapy Sessions, 1 x per week for 6 weeks, for the Bilateral Knees:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy. Decision based on Non-MTUS Citation ODG-TWC Knee and Leg Procedure Summary last updated 01/20/2014 - Aquatic therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Aquatic Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, aquatic therapy two times per week times four weeks the lumbar spine is not medically necessary. Aquatic therapy is recommended as an optional form of exercise therapy, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity so it is specifically recommended where reduced weight-bearing is desirable, for example extreme obesity. Unsupervised pool use is not aquatic therapy. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are cervical spine disc bulges; thoracic spine strain; lumbar disc bulges; right elbow strain; left elbow strain; status post left knee surgery; left ankle/foot sprain; and cephalgia. According to a progress note dated March 19, 2014 the documentation shows land-based physical therapy two times per week times three weeks was authorized. There are no physical therapy progress notes or evidence of objective functional improvement associated with land-based physical therapy. The documentation shows there is a Synvisc injection pending. The injured worker had a prior Synvisc injection with good results. The injured worker has also been declared permanent and stationary. There is no documentation with an expectation of improvement after declared with a status of permanent and stationary position. Moreover, physical therapy was authorized (land-based) two weeks prior. As noted above, there is no documentation evidencing objective functional improvement. There is no documentation with the clinical rationale for aquatic therapy (over and above land based therapy). Consequently, absent clinical documentation with a clinical rationale/indication for

aquatic therapy over and above physical therapy (authorized two weeks prior) with a pending Synvisc injection and a permanent and stationary status, aquatic therapy one time per week times six weeks to the bilateral knees is not medically necessary.

**LINT Therapy (Localized Intense Neurostimulation Therapy): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Miguel Gorenberg, Elad Schiff, Kobi Schwartz, and Elon Eizenberg, "A Novel Image-Guided, Automatic, High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain," Pain research and Treatment, Vol. 2011, Article ID 152307, 6 pages, 2011.

**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 Section, LINT Therapy.

**Decision rationale:** Pursuant to the Official Disability Guidelines, LINT (Localized Intense Neurostimulation Therapy) is not medically necessary. The guidelines do not recommend LINT (hyperstimulation analgesia) until there are higher quality studies. See the official disability guidelines for details. In this case, the injured worker's working diagnoses are cervical spine disc bulges; thoracic spine strain; lumbar disc bulges; right elbow strain; left elbow strain; status post left knee surgery; left ankle/foot sprain; and cephalgia. LINT is not recommended until the higher quality studies. There is no conclusive evidence of benefit from this treatment validate the medical necessity. Consequently, absent guideline recommendations for LINT treatment, LINT (Localized Intense Neurostimulation Therapy) is not medically necessary.