

<b>Case Number:</b>	CM15-0202580		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	12/02/2014
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 42 year old male who sustained an industrial injury on 12-02-2014. A review of the medical records indicated that the injured worker is undergoing treatment for osteoarthopathy left knee with osteophytes, patellar tendinitis and facet osteoarthopathy L3-S1. According to the treating physician's progress report on 09-11-2015, the injured worker continues to experience low back pain with lower extremity symptoms and left knee pain both rated at 8 out of 10 on the pain scale. Examination of the left knee demonstrated diffuse tenderness with one plus effusion and crepitanace with range of motion noted at 0-90 degrees. There was tenderness and swelling of the left patellar tendon. Examination of the lumbar spine noted tenderness with range of motion documented as flexion 60 degrees, extension 40 degrees and bilateral lateral tilt and bilateral lateral rotation at 40 degrees each. Straight leg raise was positive bilaterally. Deep tendon reflexes and distal pulses were intact. Lumbar spine magnetic resonance imaging (MRI) performed on 02-20-2015 interpreted within the progress note dated 04-10-2015 stated "multi-level degenerative disc disease with facet arthropathy at L4-5 and L5-S1 levels. No stenosis noted". Prior treatments have included diagnostic testing, ice, knee injections, physical therapy, home exercise program and medications. There was no discussion of prior number of physical therapy sessions completed, body area treated and the functional benefits derived. Current medications were listed as Hydrocodone 10mg and Soma. The injured worker remains on temporary total disability (TTD). Treatment plan consists of the current request for extracorporeal shockwave therapy to the left knee times 5 sessions, additional physical therapy twice a week for 4 weeks to the left knee post extracorporeal shockwave

therapy sessions, additional physical therapy to the lumbar spine three times a week for 4 weeks and Genetic-DNA testing to rule out metabolic pathway deficiency for proper medications selection and management. On 10-02-2015 the Utilization Review determined the request for extracorporeal shockwave therapy to the left knee times 5 sessions, additional physical therapy twice a week for 4 weeks to the left knee post extracorporeal shockwave therapy sessions, additional physical therapy to the lumbar spine three times a week for 4 weeks and Genetic-DNA testing to rule out metabolic pathway deficiency for proper medications selection and management was not medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Shockwave Therapy to the Left Knee x 5 sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee, ESWT extracorporeal shockwave therapy.

**Decision rationale:** The ODG provides the preferred mechanism for assessing clinical necessity in this case. The guidelines state that shockwave therapy is under study for patellar tendinopathy and for long-bone hypertrophic non-unions. New data presented at the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. Overall, this patient's clinical picture is not compelling for experimental treatment, and with little evidence to support the use of shockwave therapy even in more clearly diagnosed patellar tendinopathy, there is no indication for medical necessity in this case.

#### **Additional Physical Therapy 2x4 weeks to the Left Knee Post Shockwave Therapy Sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) do not indicate that manual therapy and manipulation are recommended as options in chronic knee or shoulder pain. At this point the patient is fairly far from the initial date of injury and with no objective evidence to indicate an acute re-injury or exacerbation, making the knee pain chronic in nature. Without strong evidence for physical therapy being beneficial in chronic cases of knee and shoulder pain and with no formal objective plan to measure and evaluate functional

improvement, medical necessity of further physical therapy cannot be justified as any greater than a home exercise program emphasizing education, independence, and the importance of on-going exercise.

**Additional Physical Therapy to the lumbar spine 3 times/week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement prior to the completion of 12 visits in order to meet the standards outlined in the guidelines. Overall, it is quite possible the patient may benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request for a total of 12 visits to physical therapy without a definitive plan to assess for added clinical benefit prior to completion of the entire course of therapy is not considered medically necessary.

**Genetic/DNA testing to r/o metabolic pathway deficiency for proper medications selection/management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** In this case, the requested labs are not specifically clear with respect to labs requested or to with clinical indication. A genetic workup is unlikely to be appropriate under compensation as a part of this musculoskeletal claim. Some labs may be appropriate in preparation for surgery, etc., however, without clear indication for operative intervention, preoperative work-up is not clinically necessary at this time. Should operative management be the appropriate decision, supported by exam findings and imaging studies, some labs may be an appropriate request in preparation for surgery. Therefore, at this time, based on the provided documents and lack of clear plan for operative intervention, and uncertainty as to the justification

for starting a genetic work-up in a work-related injury case as no evidence-based guidelines recommend pharmacologic testing; the requested labs are not considered medically necessary.