

Case Number:	CM15-0244031		
Date Assigned:	12/23/2015	Date of Injury:	08/24/2014
Decision Date:	01/28/2016	UR Denial Date:	11/13/2015
Priority:	Standard	Application Received:	12/15/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 40 year old male who sustained an industrial injury on 08-24-2014. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar radiculopathy and thoracic spine pain. The injured worker has a medical history of diabetes mellitus and sleep apnea. According to the treating physician's progress report on 11-03-2015, the injured worker continues to experience lower back pain radiating to the right buttock and right thigh associated with pins and needle sensation and rated at 8-9 out of 10 on the pain scale and right knee pain rated at 6-9 out of 10 on the pain scale. The injured worker reported 50% relief for over 6 hours with Ultracet and over 8 hours relief with Norco. Examination noted a body mass index of approximately 53-54 with a mild antalgic gait and abnormal heel to toe walk. Examination demonstrated tenderness to palpation in the midline and bilateral paraspinal muscles of the thoracic and lumbar spine with decreased range of motion throughout the lumbar spine. There was decreased sensation over the right L5 and S1 dermatomes. Motor strength was noted as 5 minus out of 5 in the right psoas, quadriceps and hamstrings and 4+ out of 5 in the left tibialis anterior, extensor hallucis longus muscle, invertors, plantar flexor and evertors and 5 out of 5 in the lower extremities. Reflexes were hypo-reflexive in the bilateral upper and lower extremities. Positive straight leg raise on the right at 30 degrees with pain to the knee, positive slump test on the right, positive Lasegue's maneuver on the right and positive facet loading at the lower lumbar spine were documented. Official reports of electrodiagnostic studies of the bilateral lower extremities performed on 09-14-2015 were included in the review and interpreted in the progress notes dated 11-03-2015. Right knee magnetic resonance imaging (MRI) (no date

documented) noted a meniscus tear. Prior treatments have included diagnostic testing, back physical therapy (6 sessions), right knee physical therapy (8 sessions), right knee cortisone injections (05-2014), chiropractic therapy for the right knee, transcutaneous electrical nerve stimulation (TENS) unit, local ice and heat therapy, knee brace, home exercise program and medications. Current medications were listed as Norco, Ultracet and Naproxen. Treatment plan consists of weight loss, diet change, discontinuation of Ultracet 37.5-325mg and add Ultram 100mg, refill Anaprox and Norco, continuing chiropractic therapy and the current request for unknown # of sessions of extracorporeal shockwave therapy, unknown # of sessions of localized intense neurostimulation therapy and one (1) trigger point impedance imaging. On 11-13-2015 the Utilization Review determined the requests for unknown # of sessions of extracorporeal shockwave therapy, unknown # of sessions of localized intense neurostimulation therapy and one (1) trigger point impedance imaging were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown sessions of extracorporeal shockwave therapy: 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) Knee and leg (Acute & Chronic) Extracorporeal 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) Extracorporeal shock wave therapy, Knee/Leg, Back.

Decision rationale: The request for ESWT is not medically necessary. MTUS guidelines do not address this. ODG has guidelines for ESWT of knee/leg, but not for lumbar spine. ESWT is currently being studied for patellar tendinopathy and for long-bone hypertrophic non-unions which the patient was not diagnosed with. There is no evidence of the effectiveness of ESWT for lumbar pain. The patient has not failed conservative therapy and has responded well to medications. There was no clear rationale as to why ESWT was prescribed at this time. And the number of sessions was not specified. Therefore, the request is considered not medically necessary.

1 trigger point impedance imaging: 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) low back: Lumbar & Thoracic (Acute & Chronic): Trigger point impedance imaging.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: trigger point impedance imaging, back.

Decision rationale: The request is considered not medically necessary. MTUS guidelines do not address the use of trigger point impedance imaging. According to ODG guidelines, trigger point

impedance imaging is not recommended. The patient has not failed conservative therapy and has responded well to medications with improvement in pain and function. Therefore, the request is considered not medically necessary.

Unknown sessions of 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 Official Disability Guidelines (ODG) low back-Lumbar & Thoracic (Acute & Chronic): Hyperstimulation analgesia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Localized high-intensity neurostimulation- back.

Decision rationale: The request is considered not medically necessary. MTUS guidelines do not address the use of LINT; therefore, ODG guidelines were used. According to ODG guidelines, this treatment is not recommended until there are higher quality studies. Initial results were promising but studies were low quality and sponsored by the manufacturer of the devices. The patient has not failed conservative therapy and has responded well to medications with improvement in pain and function. Therefore, the request is considered not medically necessary.