

Case Number:	CM14-0144727		
Date Assigned:	09/12/2014	Date of Injury:	08/26/2005
Decision Date:	10/14/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/08/2014

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 Orthopedics and is licensed to practice in Arizona. 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:

This 53-year-old male welder sustained injuries to the knees due to accumulative trauma; the date of injury was designated as 8/26/2005 but actually occurred over a period stretching from 2000 to August 29, 2005. He was aware of mostly knee pain in 2000 but at the time believed it would go away in due course. He self-treated with warm baths but eventually sought legal counsel & was referred to a chiropractor, orthopedic surgeon, and weight management/pain specialist over time. He asked the company for transfer to another department due to the heavy lifting, but his request was denied. He was eventually allocated to the night shift, with some relief of symptoms. Due to ongoing complaints, he developed spells of depression accompanied by financial concerns (his house was in foreclosure at one time) and marital problems. He stopped working in August 2005 and has been out of work since. During this time his weight became uncontrollable and his BMI is presently in the morbid obese range. He was also arrested for DUI and served a 2-month jail sentence in 2007. Due to severe emotional distress, he received treatment consisting of medication and individual supportive psychotherapy on a weekly basis for 12 weeks. The first mention of prominent low back pain as well as numbness of legs and feet was between March 3, 2006 and November 2010 (7/31/2006). At the time he was placed on the following drugs by a pain management physician: Aspirin, Zocor, Hydrochlorothiazide, Metoprolol, Isosorbide Dinitrate, Anaprox, Tizanidine, Norco, and Prilosec. He was initially treated mostly for bilateral knee-related problems (left knee greater than right knee); this review concerns primarily factors related to his spine problem. He also complained of swelling of the feet, great toe & ankles (diagnosed with gout previously). He was advised arthroscopic surgery and right medial meniscectomy but had continued knee pain despite undergoing these procedures. He was under the care of a chiropractor, received physical therapy (experiencing only temporary benefit), received acupuncture (2 sessions with no benefit), was

referred to an orthopedic surgeon (mostly for his knee problem) and, finally, was also referred to a weight loss and pain management physician. The injured worker was also referred for bypass surgery but was denied. The last clinical documentation, dated 9/4/2014 (an Agreed Medical Evaluation), stated that low back pain was due to a compensatory altered gait pattern resulting from knee-related issues. The history is as follows: low and mid back pain radiating to buttocks starting a few months after he started to work at the company. He complained of low back pain (LBP) since last visit. An orthopedic surgeon did not think the back-related symptoms were related to the knee complaints (per note dated 5/13/2009). Ibuprofen helped initially. Low back pain varied from 1/10 - 3-5/10 on the VAS (visual analog scale). Also mentioned was swelling of the feet, great toe & ankles (was aware of gout diagnosis for 2 years). He was told he had a right medial meniscus tear & subsequently underwent a medial meniscectomy (10/17/2013). Arthroscopic surgery was done on 10/17/2013. The physical examination of the lumbar spine revealed no deformity, local tenderness L5-S1 or muscle spasms. As noted, he was morbidly obese (especially the lower extremities), heel & toe walking was difficult bilaterally and lumbar spine range of motion [ROM] was normal but painful. A neurological examination revealed negative findings assessing nerve root compression and nerve root tension signs. On 2/25/2014 there was a positive straight leg raise test bilaterally, and decreased motor strength of the lower extremities was reported (no further detail). Bilateral foot and ankle examination was normal. Treatments rendered since day of injury include: physiotherapy [PT], 12 sessions prescribed including home exercise program [HEP]; chiropractic treatment; acupuncture (scheduled for 8 sessions); drug treatment including pain management; Naprosyn; Prilosec; usage of a cane, mostly for knee problem; extracorporeal shockwave therapy procedure (ESWT) #1 on 9/21/2012; ESWT #2 on 1/24/2013; and ESWT #3 on 10/19/2012. There was no documentation of outcome. Knee symptoms worsened despite knee surgery and physiotherapy. Diagnostic studies consisted of an extensive battery of psychological tests, several studies related to knee complaints, and lumbar spine views; 6 views were reported as normal on 5/13/2009. Repeat lumbar views later revealed moderate lumbar disc narrowing at levels L4-5 & L5-S1. The diagnosis was documented as mild lumbar sprain on 5/13/2009 and lumbar disc herniation on 2/25/2014. Recommendation was for shockwave therapy for the lumbar spine (quantity 1), prescribed on 5/14/2014. Also suggested was continuation of physiotherapy for the knee problem. Work status was categorized as total temporary disability (TTD), and he was at maximum medical improvement (MMI) status for the knee. Utilization review denied the request for shockwave therapy on 8/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy sessions for the lumbar spine (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), Shockwave therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine, Shock Wave Therapy

Decision rationale: The MTUS guidelines do not address this treatment modality for the lumbar spine. The Official Disability Guidelines (ODG) do not recommend shockwave therapy to be used in the treatment of low back disorders because the available evidence does not support the effectiveness of this form of therapy for treating low back pain. This form of treatment is not just unwarranted but should also be discouraged. The MTUS only mentioned usage (negatively) in reference to lateral epicondylitis in the update to the elbow chapter. A search for further information revealed other isolated sites where authors reported on the usage of this treatment in non-randomized reports. An abstract titled "A New Application for Extracorporeal Shock Wave Therapy" By R Akopyan MD PHD (Israel) was presented at the 6th International Congress (Orlando) of the ISMST (International Society Musculoskeletal Shockwave Therapy). These preliminary results indicate effectiveness in the treatment of spinal pathologies. Nevertheless, due to the relatively small number of patients presented in this summary, it is recommended to conduct an additional clinical study (referring to evidence-based medicine) in order to further study the different aspects related to spinal treatment with ESWT. Evidence-based medicine focuses on the need for health care providers to rely on a critical appraisal of available scientific evidence, rather than clinical opinion or anecdotal reports, in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision making. Therefore, this request is not supported as medically necessary.

