

Case Number:	CM15-0148045		
Date Assigned:	09/04/2015	Date of Injury:	10/18/2001
Decision Date:	10/13/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/30/2015

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: Georgia, California, Texas

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 62 year old male who sustained an industrial injury on 10-18-2001 when he developed a severe headache with loss of consciousness and coma for 17 days due to work related stress and pressure. The injured worker was diagnosed with intracranial hemorrhage, left sided paralysis and underwent shunting. The injured worker was also diagnosed with post coma condition, cervical spine degenerative disc disease, lumbar degenerative disc disease, thoracic or lumbosacral neuritis or radiculitis, bilateral shoulder impingement, bilateral ankle posterior tibial tendinitis, bilateral plantar fasciitis, hypertension, hearing loss, atrial fibrillation, insomnia and depression. The injured worker is status post brain surgery with shunt insertion in October 2001. Treatment to date has included diagnostic testing, podiatry consultation, audiology evaluation, psychiatric and psychological evaluation and treatment, physical therapy, acupuncture therapy, cardiac work-up, neurosurgical and neurology consultation and follow-up, orthopedic ambulatory devices, orthotics, steroid injections, gym membership, home maintenance care and medications. According to the agreed medical examiner's report on May 12, 2015, the injured worker continues to experience neck pain associated with headaches, bilateral shoulder pain, left greater than right, low back pain, bilateral knee pain, right foot and ankle pain and memory loss. The injured worker no longer requires the use of ambulatory devices. Examination demonstrated tenderness to palpation of the paraspinal muscles and decreased cervical spine range of motion with pain towards the terminal ranges. The bilateral shoulders were noted to have decreased range of motion bilaterally with pain against resistance on abduction and myofascial tenderness to palpation of the bilateral trapezius muscles. The lumbar spine examination demonstrated

tenderness to palpation of the paraspinal muscles and spinous process with decreased range of motion and pain at end point range and positive seated and supine straight leg raise bilaterally. Bilateral knees revealed popping and crepitus bilaterally, right greater than left with pain on range of motion of the right knee. Provocative tests of the knees were negative. The bilateral ankles and feet noted mild tenderness to palpation over the inner ankles with full range of motion and negative testing. Waddell's signs were absent. On June 4, 2015, the bilateral ankles were further evaluated as unchanged from previous office visits with dorsiflexion of the left ankle noted at 17 degrees with guarding. The injured worker declined injections at this time. Current medications were listed as Dilantin, HCTZ (hydrochlorothiazide), Ambien, and Viagra and over the counter analgesics. Cervical, thoracic, and lumbar spine motor strength was 5 out of 5. Treatment plan consists of continuing ice and stretching of the ankles and feet, castings for custom functional orthotics, creams for feet and ankles, continuing medication regimen, avoid walking barefoot and the current request for extracorporeal shockwave therapy for bilateral plantar fasciitis to reduce pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave Therapy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle and Foot.

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods, Summary.

Decision rationale: The submitted office notes document a diagnosis of plantar fasciitis. The ACOEM Occupational Medicine Practice Guidelines Ch. 14 (Ankle & Foot Complaints) section on Physical Methods states: "Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in treating plantar fasciitis to reduce pain and improve function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy." However, Table 14-6, Summary of Recommendations for Evaluating and Managing Ankle and Foot Complaints, recommends optional use of ESWT for treatment of plantar fasciitis. Based upon the documented clinical findings and failure of other conservative treatments, a trial of ESWT for treatment of plantar fasciitis is reasonable and medically necessary.