

<b>Case Number:</b>	CM14-0077932		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	03/28/2012
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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: Florida

Certification(s)/Specialty: Neurology, Pain Management

### 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 68 year old male sustained an industrial injury on 3/28/12. He subsequently reported left knee pain. Diagnoses include right shoulder impingement syndrome, left knee medial meniscus tear and sprain and strain of knee and leg. The injured worker continues to experience left knee pain. Upon examination of the left knee, tenderness was noted along the left knee medial joint line, painful range of motion and McMurray's is positive on the left. The right shoulder revealed tenderness along the AC joint, Neer and Hawkins-Kennedy impingement testing were positive on the right. A request for MRI left knee, extracorporeal shock wave for the knee, functional capacity evaluation, physical therapy evaluation and treatment for left knee 3 times a week for 4 weeks and Gabapentin - 10% Amitriptyline -10% Dexamethorphan- 10% 240gm was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Left Knee:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee and Leg Chapter Imaging.

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

**Decision rationale:** The medical records report knee pain with failure of therapy for more than 3 months with reported physical deficits of tenderness, positive impingement sign. MTUS supports imaging to evaluate etiology of condition when red flags (such as weakness and atrophy) are noted. As such, the medical records support MRI of the knee congruent with ODG guidelines. The request is medically necessary.

**Extracorporeal Shockwave Therapy for the knee: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Web 2014 extracorporeal shock wave treatment.

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

**Decision rationale:** ODG supports that there is no evidence of effectiveness of shockwave therapy. The available medical records do not demonstrate findings in support of shock wave therapy demonstrating extraordinary circumstances to support this therapy. As such the records do not support this therapy at this time. The request is not medically necessary.

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs).

**Decision rationale:** The claimant has undergone treatment but has not been recommended by the treating provider to return to work. Ongoing treatment is being reported and the records do not support the insured is at MMI. As such FCE is not supported under MTUS is provide guidance on functional ability to return to work. The request is not medically necessary.

**Interferential Unit Moist Heat Pads: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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, interferential unit Not generally recommended. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz).

**Decision rationale:** The use of interferential therapy is not supported by ODG guidelines. ODG guidelines state this therapy is not generally recommended. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. The medical records provided for review do not indicate any mitigating condition or findings to support use of this therapy. As such the medical records do not support use of inferential therapy congruent with ODG guidelines. The request is not medically necessary.

**Physical Therapy Evaluation and treatment for Left Knee 3 times a week for 4 weeks:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The medical records indicate Knee with physical deficits of tenderness and positive impingement sign. MTUS supports PT for identified deficits with goals of therapy. The medical records support the presence of ROM deficits for which PT may benefit the insured. As such MTUS supports PT evaluation with 12 sessions. The request is medically necessary.

**Gabapentin - 10% Amitriptyline -10% Dextromethorphan- 10% 240gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The medical records provided for review do not indicate a neuropathic pain condition with associated hyperalgesia/allodynia. The records do not indicate the specific medications failed, specifically trials of antidepressants and anticonvulsants. MTUS supports this agent is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As the records do not indicate neuropathic pain condition or specific antidepressants and anticonvulsants tried and failed, the medical records do not support use of this medication congruent with MTUS. The request is not medically necessary.

**Flurbiprofen 20% Tramadol 20% 240gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. The medical records provided for review indicate a neuropathic pain condition with associated hyperalgesia / allodynia. The records report poor tolerance to oral medications but does not indicate the specific medications failed, specifically trials of antidepressants and anticonvulsants. MTUS supports this agent is Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As the records do not indicate specific antidepressants and anticonvulsants tried and failed, the medical records do not support use of this medication congruent with MTUS. The request is not medically necessary.