

<b>Case Number:</b>	CM13-0010196		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	01/15/2009
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	08/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in California. 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:

The underlying date of injury in this case is 01/15/2009. The primary diagnosis is a lumbar sprain. Additional diagnoses include status post femur fracture as well as status post removal of retained hardware. On 06/17/2013, the patient's primary treating orthopedic physician saw the claimant in followup and noted the patient was 6 months status post removal of hardware and continued to complain of pain in his hip and left lower extremity as well as lower back and left leg pain. The patient had been attending aquatic therapy and had a few more sessions left to complete. These had helped him a great deal, although the patient had continued difficulty with ambulation and mobility. The patient had an antalgic gait with a cane. The treating physician noted that the patient requested a motorized scooter given his difficulties with ambulation. For pain relief the patient was requesting a muscle stimulator, such as an H-wave device, since this helped him in the past and was medically warranted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MOTORIZED SCOOTER PURCHASE:** 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 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.

**Decision rationale:** This request is not specifically discussed in the Medical Treatment Utilization Schedule. The Official Disability Guidelines discuss power mobility devices and indicate that such powered devices are not recommended if the patient is able to utilize a cane or a walker or a manual wheelchair. The medical records do indicate this patient is able to utilize a gait aid. Additionally, it is not clear that the patient would be unable to propel a manual wheelchair. For these reasons, the medical records do not support the necessity of a motorized scooter. This request is not medically necessary and appropriate.

**AQUATIC/POOL THERAPY: ADDITIONAL 2X4 SESSIONS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** The MTUS Chronic Pain Guidelines state aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy. The treating provider writes in detail in his appeal letter that aquatic therapy is necessary in this case since the patient has comorbidities of both hip and lower back pain making it difficult for the patient to perform land-based therapy. The treating physician has documented difficulties with the patient bearing weight sufficient to perform land-based exercise given residual pain from the patient's femur fracture. In this situation, aquatic therapy is supported as an alternative to land-based therapy. This treatment is medically necessary and appropriate.

**H-WAVE ELECTRICAL STIMULATOR: PURCHASE OR 30DAY RENTAL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT) Page(s): 117-118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend a one-month home trial of H-wave as an option for treating soft tissue inflammation following failure of specifically defined initial care, including physical therapy, medications, and the use of a TENS unit. It is not clear if the patient has met these requirements, particularly a trial of a TENS unit prior to considering H-wave stimulation. Moreover, H-wave is intended for use as part of an overall program of evidence-based functional restoration. It is not clear whether there is such a functional restorative plan in place currently as recommended by the MTUS Chronic Pain Guidelines. For these multiple reasons, the MTUS Chronic Pain Guidelines' criteria have not been met. The request for an H-wave stimulator is not medically necessary and appropriate.