

<b>Case Number:</b>	CM13-0034631		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	10/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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 patient is a 63 year old male who reported a work related injury on 07/24/2012, as the result of a fall. The patient subsequently sustained a burst fracture of the T12 with retropulsion into the spinal canal; however, without neurological deficit. The patient subsequently underwent decompression and fusion as of 09/26/2012. The patient presents for treatment of thoracic pain and low back pain. The clinical note dated 08/20/2013 reports the patient was seen under the care of [REDACTED]. The provider documents the patient reports complaints of dull aching pain and occasional severe flare-ups to the mid and low back. Upon physical exam of the patient, the provider documents the patient's range of motion about the thoracic spine was within normal limits, lumbar spine range of motion was 10 degrees flexion, 0 degrees extension, right lateral bend 10 degrees, left lateral bend 15 degrees. The patient had negative straight leg raise bilaterally. Reflexes were 1+ throughout. Sensation was noted as intact and the patient had 5/5 motor strength noted throughout. The provider documented the patient was status post burst fracture of T12, status post open reduction, internal fixation with pedicle screw at the T11 through L1. The provider documented the patient would attempt to maximize benefit relative to the low back with further conservative treatment to include bracing, anti-inflammatory medication therapy, and H-wave treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 x week x 4 week lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. .

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** The request for physical therapy 3 times a week for 4 weeks for the lumbar spine is non-certified. The California MTUS Guidelines indicate allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. The patient presents with chronic thoracic, lumbar spine pain complaints. The patient has decreased range of motion about the lumbar spine. Having any neurological, motor, or sensory deficits was not evidenced in the clinical notes reviewed. At this point in the patient's treatment, utilization of an independent home exercise program would be indicated, as there were no physical therapy progress notes submitted for review revealing the patient's reports of efficacy with previous supervised therapeutic interventions. Given the above, the request for physical therapy 3 times a week for 4 weeks for the lumbar spine is not medically necessary or appropriate.

**H wave unit for home use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines H-wave Stimulation. Decision based on Non-MTUS Citation ODG for Low Back regarding Lumbar Supports

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

**Decision rationale:** The current request is not supported. California MTUS Guidelines indicate H-wave is not recommended as an isolated intervention, but a 1 month home based trial of H-wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain or choric soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care including recommended physical therapy, medications, plus transcutaneous electrical nerve stimulation. There is no evidence that H-wave is more effective as an initial treatment when compared to TENS for analgesic efforts. The clinical notes fail to document the patient reports poor efficacy with utilization of a TENS unit, or that the patient has undergone a 1 month home based trial of an H-wave for his pain complaints. Given the above, the request for H-wave unit for home use is not medically necessary or appropriate.