

Case Number:	CM13-0044143		
Date Assigned:	12/27/2013	Date of Injury:	01/03/2007
Decision Date:	02/24/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	10/28/2013

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 New York and Texas. 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 43-year-old female who reported an injury on 01/03/2007. The patient is currently diagnosed with arthrofibrosis in the lumbar spine, rectus abdominis/anterior abdominal wall pain, intermittent bilateral lower extremities edema, status post L4-5 TDA and L5-S1 anterior and posterior fusion, L4-5 and L5-S1 disc degeneration and annular tear, and postoperative bilateral L4 radiculopathy. The patient was seen by [REDACTED] on 10/11/2013. The patient was actively participating in a physical therapy course; however, the patient noted no improvement in pain and continues to have bedridden days. The patient reported 6/10 persistent lower back pain, with radiation to the bilateral lower extremities. Physical examination revealed an antalgic gait, tenderness to palpation, hypersensitivity over the right L5 and S1 distributions, diminished range of motion, decreased hip flexion strength, and negative straight leg raise. Treatment recommendations included additional physical therapy twice per week for 6 weeks, as well as authorization for an H-wave unit trial with purchase if beneficial.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave unit trial for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT), pages 117-121 Page(s): 117-121.

Decision rationale: The Chronic Pain Guidelines indicate that H-wave stimulation is not recommended as an isolated intervention, but a one (1) month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. The guidelines also indicate that H-wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following a failure of initially recommended conservative care, including physical therapy, medications, and TENS therapy. As per the documentation submitted, there is no evidence of failure to respond to previous conservative treatment including medications and transcutaneous electrical nerve stimulation. Therefore, the patient does not currently meet criteria for an H-wave stimulation trial. As such, the request is non-certified.

Physiotherapy two (2) times a week for six (6) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, pages 98-99 Page(s): 98-99.

Decision rationale: The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the clinical documentation submitted, the patient has previously completed a course of physical therapy. Despite ongoing treatment, the patient continues to report persistent pain. It is also noted on 10/11/2013 that the patient reported no improvement in pain or symptoms following physical therapy. As there is no documentation of significant functional improvement, ongoing treatment cannot be determined as medically appropriate. As such, the request is non-certified.