

<b>Case Number:</b>	CM14-0013856		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	01/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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. 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 patient is a 39-year-old male who has submitted a claim for persistent back pain with left lower extremity sciatica in the setting of L5-S1 disc herniation, resulting in foraminal stenosis and lumbar disc degeneration associated with an industrial injury date of 06/05/2013. Medical records from 06/10/2013 to 02/28/2014 were reviewed and showed that patient complained of constant low back pain radiating to left buttock and posterolateral thigh, calf, and bottom of foot. Pain was aggravated with sitting. Physical examination revealed restricted lumbar ROM. MMT and DTRs were intact for bilateral lower extremities. Sensation to light touch was decreased in the left lower leg and dorsum of foot. SLR test was positive on the left leg. X-ray of the lumbar spine dated 06/10/2013 revealed normal findings. MRI of the lumbar spine dated 08/24/2013 revealed mild facet arthropathy at left L5-S1 and neural foraminal stenosis. EMG-NCV study of bilateral lower extremities dated 08/15/2013 revealed acute left L5 and S1 lumbosacral radiculopathy. Treatment to date has included L5-S1 transforaminal epidural steroid injection (01/14/2014), physical therapy, TENS, HEP, activity modification, hot/cold pack application, lumbar sacral support formfit (06/10/2013). Most recent utilization review, dated 12/27/2013 denied the request for physical therapy six visits two times a week for three weeks because physical therapy should be only be considered after the patient has achieved significant relief with ESI and not before. The requests for H-wave unit rental x 3 months and lumbar pillow were likewise denied; however, reasons for the denial were not made available.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AQUA THERAPY WITH THERAPEUTIC EXERCISES 2 TIMES A WEEK FOR 6 WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY.

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

**Decision rationale:** According to page 22 of the CA MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable. In this case, the patient's BMI is 24 kg/m<sup>2</sup> (Weight: 79 kg Height 1.80 m based on 12/03/2013 record) which is classified as normal. There is no objective evidence that supports land based physical therapy as inappropriate for the patient. It is unclear as to why aquatic therapy is needed. The body part to be treated is likewise not specified. Therefore, the request for aqua therapy with therapeutic exercises 2 times a week for 6 weeks is not medically necessary.

**H-WAVE UNIT RENTAL FOR 3 MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-120.

**Decision rationale:** According to pages 117-120 of CA MTUS Chronic Pain Treatment Guidelines, H-Wave stimulation is not recommended as a primary treatment modality, but a one-month home-based H-Wave stimulation trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. It should be 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). A one month trial period of the H-wave stimulation unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, the patient has already completed unspecified visits of physical and TENS therapy. However, there was no documentation of functional outcome from these modes of treatment. Moreover, the patient was not documented to be actively participating in a functional restoration program. H-wave cannot be used as a primary mode of treatment and the request likewise failed to mention the specific body part to be treated. Finally, the guidelines do not allow a trial beyond 30 days without documentation of pain relief and functional outcome with recent H-wave use. Therefore, the request for H-wave unit rental for 3 months is not medically necessary.

**LUMBAR PILLOW:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** According to page 301 of the ACOEM Practice Guidelines referenced by CA MTUS, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, the patient has used lumbosacral support (06/10/2013) without documentation of pain relief. The use of lumbar pillow for chronic lumbar pain is not in conjunction with guidelines recommendation. There is no clear indication for the request based on the medical records provided. Therefore, the request for lumbar pillow is not medically necessary.