

Case Number:	CM14-0195365		
Date Assigned:	12/03/2014	Date of Injury:	03/29/2008
Decision Date:	01/15/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	11/21/2014

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 Internal Medicine and is licensed to practice in Washington DC, Virginia. 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:

This is a 60 year old patient who sustained injury on Mar 29 2008. She had issues with right shoulder pain, low back pain and right knee pain. She underwent right shoulder debridement of the rotator cuff and labrum, right shoulder subacromial decompression and right shoulder partial synovectomy. She was diagnosed with chronic lower back pain, lumbar herniated disc L5-S1 and lumbar radiculopathy, small disc protrusion at C5-7 with mild stenosis, cervical radiculopathy, bilateral knee pain and bilateral shoulder pain. She was prescribed Percocet, Lyrica, Elavil, Voltaren gel. She had issues with ongoing pain of the left knee and left shoulder. An MRI of the left shoulder on Jul 12 2014 showed a small partial thickness tear on the inferior aspect of the mid portion of the supraspinatus tendon. She was prescribed physical therapy with 12 sessions and an H wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy visits for the left knee and left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder pain guidelines

Decision rationale: Per MTUS, Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks Per ODG, the best practice physical therapy guidelines for rotator cuff syndrome/impingement syndrome and old bucket handle tear; derangement of meniscus; loose body in knee; chondromalacia of patella; and tibialis tendonitis as that which allows for fading of treatment frequency (from up to three visits per week or less to one or less), plus active self-directed home PT, 9-10 visits over eight weeks for medical treatment. As per guidelines cited, the 12 PT sessions would not be indicated.

1 Month H-wave rental: Upheld

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

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

Decision rationale: Per MTUS, the H-wave stimulation (HWT) Not recommended as an isolated intervention, but a one-month home-based trial of H- Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician-documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H-wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US.] Regarding tissue repair, another study suggests that low-frequency HWT may produce direct localized effects on cutaneous blood flow, a finding relevant for clinicians working in the field of tissue repair. (McDowell, 1999) The one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Rental would be preferred over purchase during this trial. Trial periods of more than one month should be justified by documentation submitted for review. While H-Wave and other similar type devices can be useful for pain management, they are most successfully used as a tool in combination with functional improvement. H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as transcutaneous electrical nerve stimulation (TENS), in terms of its waveform. While physiatrists, chiropractors, or podiatrists may perform H-wave stimulation, H-wave devices are also available for home use. H-wave stimulation is sometimes used for the treatment of pain related to a variety of etiologies, muscle sprains, temporomandibular joint dysfunctions or reflex sympathetic dystrophy. In fact, H-wave is used more often for muscle spasm and acute pain as opposed to neuropathy or radicular pain, since there is anecdotal evidence that H-Wave stimulation helps to relax the muscles, but there are no published studies to support this use, so it is not recommended at this time. H-wave stimulation has also been used to accelerate healing of wounds, such as diabetic ulcers. H-wave electrical stimulation must be distinguished from the H-waves that are a component of electromyography. (BlueCross BlueShield, 2007) (Aetna, 2005) Recent studies: A recent low quality meta-analysis concluded that the findings indicate a moderate to strong effect of the H-Wave device in providing pain relief, reducing the requirement for pain medication and increasing functionality, with the most robust effect observed for improved functionality, suggesting that the H-Wave device may facilitate a quicker return to work and other related daily activities. The low quality rating for this "meta-analysis" is primarily because the numbers were dominated by results from studies that were not prospective randomized controlled trials, but instead were retrospective observational studies using a patient survey, the H-Wave Customer Service Questionnaire, without a prospective control group. More definitive results may be on the way. According to this study, "double-blinded studies of the H-Wave device are currently underway and results will be awaited with interest." (Blum, 2008)