MAXIMUS Federal Services

Case Number:	CM15-0137032		
Date Assigned:	07/27/2015	Date of Injury:	02/17/2014
Decision Date:	08/21/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

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 injured worker is a 49 year old female, who sustained an industrial injury on 2/17/2014. Diagnoses include cervical strain and brachial radiculopathy status post two surgical procedures. Treatment to date has included surgical intervention (most recent is an anterior cervical diskectomy and fusion (ACDF), 5/2015) as well as conservative treatment consisting of medications that include Soma and oxycodone. Per the Primary Treating Physician's Progress Report dated 7/02/2015, the injured worker reported continuing significant pain in her neck which radiates out into the trapezius muscle and arm. Physical examination revealed palpable pain and discomfort with restricted range of motion of the cervical spine. The plan of care included follow-up care. Authorization was requested for and H-wave unit and home therapy versus outpatient therapy x 9 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home therapy versus outpatient therapy x 9: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder & neck and upper back (acute and chronic).

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: As per MTUS post surgical guidelines, physical therapy is recommended after maturity of fusion. However, the request is not appropriate. Decision of home vs. outpatient therapy is a clinical decision and is not up to the whim or desire of the patient. The provider needs to make an actual definitive request and not leave it open ended. There is no documentation of patient being home bound. While outpatient physical therapy is recommended, this request is not appropriate and is therefore not medically necessary.

H-wave for home use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder (acute and chronic), neck and upper back (acute and chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118.

Decision rationale: As per MTUS Chronic pain guidelines H-Wave stimulation (HWT) is not recommended as an isolated therapy. It may be recommended in cases of diabetic neuropathy and chronic soft tissue inflammation with a successful 1month trial if used as part of an evidence based functional restoration program. Several criteria needs to be met before HWT may be recommended. 1) Failure of conservative therapy. Fails criteria. Patient is post surgical and has no documentation of failed post-surgical conservative care. 2) Failure of TENS therapy. Fails criteria. There is no documentation of failure of TENS. 3) Needs to be used as part of a functional restoration program, should not be used as an isolated treatment. Fails criteria. There is no documentation of an actual functional restoration program or what the end goal of HWT is suppose to be. 4) Successful trial of HWT for 1month: Fails criteria. There is no documentation of any HWT trial. Patient does not meet any recommended for HWT. H-wave unit is not medically necessary.