

Case Number:	CM14-0137625		
Date Assigned:	09/05/2014	Date of Injury:	06/06/2006
Decision Date:	09/30/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/25/2014

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 and Rehabilitation, has a subspecialty in Pain Management 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 51 years old male with an injury date on 06/06/2006. Based on the 07/16/2014 progress report provided by [REDACTED], the diagnoses are: 1. Stenosis of the lumbar spine 2. Lumbar radiculopathy According to this report, the patient complains of ongoing back and leg pain. The pain is described as aching, cramping pain with numbness in the lower extremities. The patient rated the pain as a 7-8/10. The patient has "more pain with ambulation that extending into the back region and the right hip." The patient is able to walk for 6-8 minutes before he requires to rest. Physical exam reveals the patient's gait is markedly antalgic and he is walking with the aid of a cane. There is diffuse tenderness to palpation over the lumbar paraspinals region. Lumbar range of motion is restricted. There were no other significant findings noted on this report. The utilization review denied the request on 08/12/2014. [REDACTED] is the requesting provider and he provided treatment report 07/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave replacement device and supplies: 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, 118.

Decision rationale: According to the 07/16/2014 report by [REDACTED] this patient presents with ongoing back and leg pain. The provider is requesting H wave replacement device and supplies. Regarding H wave units, MTUS guidelines page 117, 118 supports a one-month home-based trial of H-Wave treatment as a noninvasive conservative option for neuropathic pain 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 (TENS). Review of report shows the patient "is 20% worse and is having issue with trembling" since his previous appointment. Date of previous appointment was not provided in the report. Per the provider, the H- wave "helps with his pain level. "However, there were no pain reduction and functional gains note in the patient. MTUS page 8 requires that the treating physician provide monitoring and make appropriate recommendations. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Therefore, the requested device replacement and supplies is not recommended. Recommendation is for denial.

Wrap around hinged knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

Decision rationale: According to the 07/16/2014 report by [REDACTED] this patient presents with ongoing back and leg pain. The provider is requesting wrap around hinged knee brace. The utilization review denial letter "clinical findings failed to show any severe instability." ACOEM guidelines page 340 state "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical." When ODG guidelines are consulted, criteria for knee bracing is much broader. However, this patient still does not qualify as the patient does not have articular defect repair, meniscal cartilage repair, knee instability, ligament insufficiency, etc. Neither ACOEM nor ODG guidelines support the use of knee bracing for this patient's diagnoses. Recommendation is for denial.