MAXIMUS Federal Services

Case Number:	CM14-0143735		
Date Assigned:	09/12/2014	Date of Injury:	02/04/2011
Decision Date:	10/10/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/04/2014

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:

This is a patient with a date of injury of February 4, 2011. A utilization review determination dated August 26, 2014 recommends noncertification of an H wave unit and physical therapy. A progress report dated May 6, 2014 identifies subjective complaints of left medial knee pain. The note indicates that a urine drug screen revealed oxycodone and no hydrocodone. Current medications include Pennsaid, ibuprofen, and Norco. The physical examination reveals edema in the left knee, tenderness to palpation around the left knee medial joint line, restricted left knee range of motion, positive crepitus, and positive clicking. Diagnoses include lumbar sprain/strain, left knee arthroscopy with limited chondroplasty, left knee in internal derangement, status post left knee surgery, left knee pain, and left knee sprain/strain. The treatment plan recommends a short course of physical therapy directed at the lumbar spine. The note goes on to state that the previous physical therapy "decreased the patient's low back pain, increased range of motion, and enable the patient to work full-time." A progress report dated August 19, 2014 includes objective examination findings of severe tenderness in the mid lumbar spine with spasm and limitation in range of motion testing. Sacroiliac testing is also positive. The treatment plan recommends continuing physical therapy and providing the patient with an H wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave unit for pain for 1 month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 117-118 of 127.

Decision rationale: Regarding the request for H-wave unit, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-wave stimulation is 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, 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation there is no indication that the patient has undergone a 30 day tens unit trial as recommended by guidelines. There is no statement indicating how frequently the tens unit was used, and what the outcome of that tens unit trial was for this specific patient. In the absence of such documentation, the currently requested H wave device is not medically necessary

Physical therapy (12 sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,Chronic Pain Treatment Guidelines Page(s): 98 OF 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends a maximum of 10 physical therapy visits for the treatment of enter vertebral disc disorders of the lumbar spine. Within the documentation available for review, it is unclear how many therapy visits the patient has already undergone. Additionally, the currently requested number exceeds the maximum number recommended by guidelines for this patient's diagnosis. Finally, there is no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. In the absence of such documentation, the current request for additional physical therapy is not medically necessary.