

Case Number:	CM13-0013902		
Date Assigned:	03/19/2014	Date of Injury:	06/07/2011
Decision Date:	05/20/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/20/2013

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 Occupational Medicine 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of June 7, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; earlier lumbar fusion surgery; and extensive periods of time off of work. In a Utilization Review Report of July 31, 2013, the claims administrator denied a request for referral to a [REDACTED] Rehabilitation Program and also denied an H-Wave home care system. The [REDACTED] Rehabilitation Program was apparently denied on the grounds that the attending provider had not performed a precursor functional capacity evaluation prior to pursuit of the program. The applicant's attorney subsequently appealed. A clinical progress note of August 1, 2013 is notable for comments that the applicant reports persistent low back pain. The applicant is status post hardware removal on February 12, 2013. The applicant was on Norco for pain relief and was having issues with depression and anxiety. Portions of her claim had been contested by the claims administrator, it was noted. The applicant's medication list included Xanax, Effexor, Pepcid, Flonase, albuterol, Norco, and Flexeril. It was stated that the applicant was concurrently pursuing an epidural steroid injection and an H-Wave device along with a [REDACTED] Rehabilitation Program. The applicant had reportedly failed to return to her former work as a hair dresser.

IMR ISSUES, DECISIONS AND RATIONALES

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

REFERRAL TO [REDACTED] REHABILITATION PROGRAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 32.

Decision rationale: As noted on page 32 of the MTUS Medical Treatment Guidelines, some of the criteria for pursuit of a chronic pain program include evidence that previous means of treating chronic pain have been unsuccessful and that there is an absence of other options which should likely result in significant clinical improvement. In this case, however, the applicant was described as pursuing a variety of other treatments, including an epidural steroid injection. Thus, there was still some hope that other means of treating chronic pain could possibly be beneficial and theoretically obviate the need for the proposed functional restoration program. It is further noted that page 32 of the MTUS Chronic Pain Medical Treatment Guidelines does support an adequate and thorough baseline evaluation prior to commencing the functional restoration program. This was not done here. Accordingly, the request is not certified as several MTUS criteria for pursuit of functional restoration program have not seemingly been met.

H-WAVE UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

Decision rationale: The request represents a request for purchase of the H-Wave device. However, the attending provider appears to have sought to purchase the device in question without evidence of a previous successful one-month trial of the same. As noted on page 118 of the MTUS Chronic Pain Medical Treatment Guidelines, usage of an H-Wave home care system beyond the one-month trial period should be justified by documentation submitted for review. In this case, however, there is no documentation of file which would justify a purchase of the device as there is no evidence that the applicant has had a previous successful one-month trial of the same, with favorable outcomes in terms of both pain relief and function. Accordingly, the request is not certified, on Independent Medical Review.