

Case Number:	CM14-0106344		
Date Assigned:	07/30/2014	Date of Injury:	02/14/2007
Decision Date:	09/03/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	07/09/2014

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 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 injured worker is a 42-year-old male with a reported injury on 02/14/2007. The mechanism of injury was not provided. The injured worker's diagnoses included L4-5 degenerative disc disease with failed surgery, L5-S1 disc herniation, left lower extremity radicular pain, status post L4-5 anterior fusion and posterior laminectomy, status post L4-5 posterior instrumented fusion with pedicle screws. The injured worker's prior treatments included a TENS unit, physical therapy, home exercise program, medications and activity modifications. The injured worker had an examination on 04/16/2014. The injured worker reported complaints of pain to his lumbar spine and bilateral lower extremity pain as well as psychological issues, sleep and internal issues. The injured worker reported back pain rated 10/10. The injured worker underwent an L4 and L5 lumbar fusion with screws and rods on 03/20/2014. He had been taking Norco and reported improvement in his pain level from a 10/10 down to a 4/10 after taking medications. His range of motion was decreased with flexion at 30 degrees, extension at 10 degrees and right and left rotation at 10 degrees. There was tenderness to the paraspinal equally. There was a positive Kemp's sign bilaterally, a positive straight leg raise on the right at 70 degrees to the posterior thigh, and a positive straight leg raise on the left at 60 degrees to the posterior thigh. His strength was normal at 5/5. The clinical note dated 05/15/2014 noted the injured worker presented with complaints of the lumbar spine pain that was persistent. The examination was not changed from the previous examination. The injured worker's medication regimen included Hydrocodone/APAP/Ondansetron. The recommended plan of treatment was for the injured worker to continue following up with a spinal surgeon, to continue his pain medications, to provide an H-wave unit and provide Kera-Tek gel. The rationale for the Kera-Tek gel was not provided. The provider recommended an H-wave device for symptomatic pains

with radicular symptoms in the left leg. The Request for Authorization was signed and dated on 05/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave unit purchase: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend H-wave stimulation as an isolated intervention but as a 1-month home-based trial of the H-wave stimulation. It is considered for diabetic neuropathic pain and for chronic soft tissue inflammation and is used in adjunct to a program of evidence-based functional restoration only following failure of initially recommended conservative care including the recommended physical therapy, medications, plus the TENS unit. There is documentation of a trial of a TENS unit before surgery which was helpful prior to surgery but was noted to be ineffective after surgery. There is no indication that the injured worker has completed a one month home based h-wave trial with documentation of the efficacy and the frequency of usage. Therefore, the request for the H-wave unit purchase is not medically necessary.

Kera-Tek gel 4oz.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, Topical analgesics Page(s): 105, 111.

Decision rationale: Kera-Tek gel is comprised of menthol and methyl salicylate. The California MTUS Guidelines note topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state that topical salicylate is significantly better than placebo in the treatment of chronic pain. There is a lack of evidence that antidepressants and anticonvulsants have been tried and failed. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. Additionally, the request does not indicate the frequency at which the medication is prescribed and the site at which it is to be applied in order to determine the necessity of the medication. Therefore, the request for the Kera-Tek gel is not medically necessary.

