

Case Number:	CM14-0123800		
Date Assigned:	08/08/2014	Date of Injury:	06/11/1999
Decision Date:	09/11/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/05/2014

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 Internal 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 injured worker is presented with 6/11/99 date of injury and was authorized for mental/physical and lower back. It was noted that on 9/25/09, the injured worker had an ESI procedure done to his lumbar spine. The treating physician noted that he had 14 years of h/o neck and back pain and that he had seen a chiropractor and had tried medications, therapy, injections, and currently H Wave . The injured worker was noted to be stable on Lidoderm patches and H wave treatment as well as cortisone injections for flares of his symptoms. He was also noted to have had MRI's and plain xrays. Diagnoses were listed as L3 L5 S1 DJD ,DDD, and facet joint DJD. The injured was also noted to have cervical disc disease, Gerd , and a history of carpal tunnel disorder. His treatment was H wave, lidoderm, and Vimovo. On exam he was noted to have paraspinal tenderness and SI joint tenderness and a 25% decrease in rom. Sensory, motor and DTR's were all noted to be normal. On 7/11/14, the patient's M.D. stated that he noted that the H-wave stimulation helped with 80% of the pain. Lastly, the UR denied use of the H-wave unit and the use of a compound pain cream comprised of Ketoprofen, Flurbiprofen, Baclofen 1%, DMSO and Versapro cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Unit for Home Use Quantity 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H Wave Stimulation Page(s): 171-172.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, chronic pain treatment pages 117 and 118 Page(s): 117-118.

Decision rationale: The H wave stimulation is a form of electrical stimulator different from other electrical stimulators in terms of its waveform. It is utilized for treatment of DM neuropathic pain and soft tissue inflammation pain. The MTUS states that the unit is not recommended as an isolated treatment but as an adjunct to a functional restoration program and following the use of other modalities such as TENS unit and physical therapy. There is no evidence that U-Wave is more effective than TENS. However, a recent study was noted to show moderate to strong effect of H-wave device in providing pain relief and decrease in need of medications and increase functionality and may facilitate return to work. In this case, the injured worker has had chronic lumbar pain for 14 years and has received multiple modalities of treatment such as physical therapy and chiropractic treatment as well as different medications. The use of H Wave provided 80% improvement per the doctor notes. We also see that the unit is utilized as part of a broader treatment using ESI injections. There is no documentation of the prior use of TENS. However, the patient improved 80% with a trial of an H wave unit. Therefore, the request for a H-Wave unit for home use, quantity 1 is medically necessary and appropriate.

Compound Cream: Ketoprofen 10%, Flurbiprofen 2%, Baclofen 1%, DMSO 10%, Versapro Cream 120 gm: 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, chronic pain treatment , pages 111 and 113 Page(s): 111-113.

Decision rationale: The MTUS states that topical analgesics are largely experimental and few randomized controlled trials have been done. They are applied locally. Also, they are used primarily in neuropathic pain when antidepressant and anticonvulsant medications have been shown to not be effective. It states that there is little research to support compounded creams. It is also stated that if one of the components is not recommended then the entire compound application cannot be recommended. In this particular patient Baclofen 1% is included in the prescribed compounded cream. However, the MTUS states that Baclofen is not recommended for topical application. Therefore, the request for Compound Cream: Ketoprofen 10%, Flurbiprofen 2%, Baclofen 1%, DMSO 10%, Versapro Cream 120gm, is not medically necessary and appropriate.