

Case Number:	CM15-0197580		
Date Assigned:	10/13/2015	Date of Injury:	09/11/2007
Decision Date:	11/23/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 52 year old male, who sustained an industrial injury on 9-11-07. The injured worker has complaints of back pain. The pain is described as aching and burning in the low back on the right, right buttock and right lower extremity. The injured worker reports he feels his medications improve his quality of life and allows him to complete his activities of daily living. The injured worker rates the pain as 9 out of 10 on a visual analog scale without medications and 6 out of 10 with medications. Lumbar spine examination reveals sensation is intact but decreased over the right lower extremity and there is tenderness over the paraspinals on the right primarily at L5-S1 (sacroiliac). There is increased pain with flexion and extension and straight leg raise is positive on the right. The diagnoses have included degeneration of lumbar or lumbosacral intervertebral disc; thoracic or lumbosacral neuritis or radiculitis, unspecified and displacement of lumbar intervertebral disc without myelopathy. Lumbar magnetic resonance imaging (MRI) on 10-28-13 revealed L1-2 no significant extradural defects are identified, there is no evidence of significant disc herniation or protrusion; L2-3 there is broad, 2-3 millimeter disc protrusion which partially compromises both exiting nerve roots, no spinal stenosis is seen; L3-4 there is a broad, 3 to 5 millimeter disc protrusion which is seen to bulge into both neural foraminal exit zones, high-grade left and moderate to high-grade right neural foraminal exit zone compromise is seen, posterior ligamentous hypertrophy is present, no spinal stenosis seen; L4-5 there is heterogenous, 5-6 millimeter disc protrusion which is midline and extends inferiorly along the posterior superior endplate of L5, this bulges into both neural foraminal exit zones, high-grade bilateral neural foraminal exit zone compromise is seen without spinal stenosis and L5-S1 (sacroiliac) there is a 3-4 millimeter disc protrusion which is seen to extend into both neural foraminal exit zones and high grade bilateral neural foraminal exit zone compromise is

seen without spinal stenosis. Bilateral lower extremity electromyography and nerve conduction velocity study on 10-29-13 revealed absent sensory nerve action potentials noted in both sural nerves; borderline prolonged H reflex latency noted on the right side and poorly formed H-reflex potential noted on the left side. Treatment to date has included transcutaneous electrical nerve stimulation unit; trazodone; gabapentin; Norco; naproxen and omeprazole. The original utilization review (9-9-15) non-certified the request for home H-wave electrodes, quantity 36; ultra gel per bottle, quantity 3 and lead wires, quantity 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave electrodes, Qty 36: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management, and Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The California chronic pain medical treatment guidelines section on H-wave stimulation therapy states: H-wave stimulation (HWT) 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 (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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 transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US.] The clinical documentation for review does not include a one-month trial of H wave therapy with objective significant improvements in pain and function. Therefore, criteria for a home unit purchase have not been met and the request is not medically necessary.

Ultra gel per bottle, Qty 3: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management, and Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The California chronic pain medical treatment guidelines section on H-wave stimulation therapy states: H-wave stimulation (HWT) 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 (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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 transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US.] The clinical documentation for review does not include a one-month trial of H wave therapy with objective significant improvements in pain and function. Criteria for a home unit purchase have not been met. As the device is not necessary, any supplies associated with the device are also not necessary. Therefore, the request is not medically necessary.

Lead wires, Qty 2: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management, and Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The California chronic pain medical treatment guidelines section on H-wave stimulation therapy states: H-wave stimulation (HWT) 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 (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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 transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US.] The clinical documentation for review does not include a one-month trial of H wave therapy with objective significant improvements in pain and function. Criteria for a home unit purchase have not been met. As the device is not necessary, any supplies associated with the device are also not necessary. Therefore, the request is not medically necessary.