

Case Number:	CM15-0200280		
Date Assigned:	10/15/2015	Date of Injury:	10/15/2001
Decision Date:	12/02/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/13/2015

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: Texas, New York, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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] beneficiary who has filed a claim for chronic low back pain (LBP) reportedly associated with an industrial injury of October 15, 2001. In a Utilization Review report dated September 3, 2015, the claims administrator failed to approve requests for an H-Wave device and a pain management referral. The claims administrator referenced the misnumbered page 151 of the MTUS Chronic Pain Medical Treatment Guidelines in its determination, also referenced non-MTUS Chapter 7 ACOEM Guidelines in the same, the latter of which were mislabeled as originating from the MTUS. An August 11, 2015 office visit was also cited. On September 24, 2015, the applicant reported ongoing complaints of low back pain status post earlier failed lumbar spine surgery in 2010. Twisting, bending, and movement remained problematic, it was reported. The applicant reported difficulty walking secondary to his pain complaints. The applicant's pain scores were characterized as progressively worse. The attending provider stated that the applicant had received an H-Wave device in physical therapy and stated that the said H-Wave device had improved his symptoms. The applicant developed derivative complaints of depression, it was acknowledged. An H-Wave device for home use purposes was sought. X-rays apparently demonstrated stable indwelling lumbar instrumentation. The applicant's work status was not explicitly detailed, although it did not appear that the applicant was working. On August 11, 2015, the attending provider again stated that usage of an H-Wave device in physical therapy had proven beneficial. An H-Wave device for home use purposes was sought. Once again, the applicant's work status was not clearly reported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Referral: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations.

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

Decision rationale: The request for a pain management referral was medically necessary, medically appropriate, and indicated here. As noted on page 1 of the MTUS Chronic Pain Medical Treatment Guidelines, the presence of persistent complaints which prove recalcitrant to conservative management should lead the treating provider to reconsider the operating diagnosis and determine a specialist evaluation is necessary. Here, the applicant was seemingly off of work. The applicant had persistent complaints of low back pain status post earlier failed lumbar spine surgery, it was reported on office visits of August and September 2015. Obtaining the added expertise of a pain management physician was, thus, indicated on several levels, including potentially for medication management purposes. Therefore, the request was medically necessary.

H-Wave Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Conversely, the request for an H-Wave unit purchase was not medically necessary, medically appropriate, or indicated here. As noted on page 118 of the MTUS Chronic Pain Medical Treatment Guidelines, provision of an H-Wave device on a purchase basis should be predicated on evidence of a beneficial outcome during earlier 1-month trial of the same, with evidence of favorable outcome present in terms of both pain relief and function prior to provision of said H-Wave device on a purchase basis. Here, however, the attending provider indicated on the August 11, 2015 office visit at issue that the H-Wave device had been endorsed on a purchase basis without the applicant's having undergone a 1-month home-based trial of the same. Rather, it appeared that the attending provider was basing his decision to prescribe the device on the applicant's having used the device as a modality during previously performed physical therapy. It did not appear, thus that the applicant had undergone the prerequisite 1-month home-based trial suggested on page 118 of the MTUS Chronic Pain Medical Treatment Guidelines prior to provision of the device on a purchase basis. Therefore, the request was not medically necessary.