

Case Number:	CM15-0202520		
Date Assigned:	10/21/2015	Date of Injury:	07/09/2014
Decision Date:	12/09/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/15/2015

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, California
 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:

This is a 54-year-old male patient who reported an industrial injury on 7-9-2014. The diagnoses include lumbar sprain-strain - lumbar region; and lumbar myospasm. Per the progress notes dated 9-16-2015, he had increased pain in-between treatment and at night, and that he needed a home "DME" equipment to improve function. The objective findings were noted to include lumbar spasms with neuralgia, with sensory loss at lumbar 5-sacral 1; positive Kemps sign and straight leg raise; pain at thoracic 4-8; and decreased spasms. Per the note dated 7/17/15, the medications list includes allopurinol, colchicine powder, cyclobenzaprine, indocin suppository and norco. The patient was prescribed biofreeze pain gel on 9/16/15. His surgical history includes knee surgery in 1973 and appendectomy in 1975. He had cervical spine MRI dated 9/18/15 which revealed degenerative changes; magnetic imaging studies of the lumbar spine dated 9-4-2014 which revealed degenerative disc disease and facet arthropathy with lumbosacral retrolisthesis and mild-moderate lumbar canal stenosis. His treatments were noted to include: an agreed medical evaluation on 6-11-2015; traction; manipulation; physical therapy; chiropractic treatment modalities; massage therapy; heat-ice therapy; medication management with toxicology studies; and rest from work. The physician's requests for treatment were noted to include: trial of H-wave, 30 days, with pad placement, settings, and treatment time; and back brace. The Request for Authorization, dated 9-16-2015, was noted for H-wave trial - 30 days trial, and back brace purchase for lumbar region sprain-strain. The Utilization Review of 9-29-2015 non-certified the request for a 30-day trial of H-wave therapy for the lumbar spine, and the purchase of a lumbar back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave. 30 day trial, lumbar spine, per 9/16/15 order qty 1.00: 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: H-wave. 30-day trial, lumbar spine, per 9/16/15 order qty 1.00. Per the CA MTUS Chronic Pain Medical Treatment Guidelines- H-wave stimulation (HWT) is "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, 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)." Evidence of diabetic neuropathy is not specified in the records provided. Evidence that an H-wave unit is used as an adjunct to a program of evidence-based functional restoration is not specified in the records provided. The details regarding previous conservative therapy including physical therapy, pharmacotherapy and TENS, were not specified in the records provided. Significant objective functional deficits that would require a H-wave were not specified in the records provided. The medical necessity of H-wave. 30-day trial, lumbar spine, per 9/16/15 order qty 1.00 is not medically necessary.

Back brace, purchase, per 9/16/15 order qty 1.00: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back (updated 12/02/15) Back brace Lumbar supports.

Decision rationale: Back brace, purchase, per 9/16/15 order qty 1.00. Rationale: Per the ACOEM guidelines, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." In addition, per the ODG lumbar support/brace is "Recommended as an option for treatment.Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of non-specific LBP (very low quality evidence, but may be a conservative option)..." Per the records, provided the patient had abnormal objective findings on the lumbar spine MRI dated 9/4/2014, which revealed lumbosacral retrolisthesis and mild-moderate lumbar canal stenosis. Therefore, the patient had evidence of spondylolisthesis, which is one of the indications for the use of a lumbar brace. In addition, the patient has a chronic back condition that is prone to intermittent acute exacerbations, during which the use of a back brace would be

medically appropriate. The request of a Back brace, purchase, per 9/16/15 order qty 1.00 is medically appropriate and necessary for this patient.