

Case Number:	CM15-0212400		
Date Assigned:	11/03/2015	Date of Injury:	11/18/2013
Decision Date:	12/18/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/28/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 38-year-old male with a date of industrial injury 11-18-2013. The medical records indicated the injured worker (IW) was treated for low back pain and myofascial pain. In the progress notes (9-25-15), the IW reported low back pain with adequate relief from Fenoprofen and home H-wave therapy. On examination (7-31-15 and 9-25-15 notes), there was full range of motion of the lumbosacral spine with some pain on forward flexion and extension. Treatments included physical therapy (with benefit), H-Wave unit (with benefit), extracorporeal shockwave therapy and medications (with benefit). The records reviewed did not contain evidence of spinal instability requiring a lumbar corset. The H-Wave unit was used successfully for at least a one-month trial, but there was no documentation of sustained functional improvement or decrease in medication use. The IW was released for work; no restrictions were reported. A Request for Authorization was received for a home H-Wave unit (indefinite use) and a lumbar corset (indefinite use). The Utilization Review on 10-6-15 non-certified the request for a home H-Wave unit (indefinite use) and a lumbar corset (indefinite use).

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Unit Device (Infinite Use) QTY: 1: 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: The patient presents with pain affecting the low back. The current request is for Home H-Wave Unit Device (Infinite Use) QTY: 1. The treating physician report dated 9/22/15 (31B) does not note that the patient has failed a TENS unit or that the patient has received a 30 day in home trial. The MTUS guidelines regarding H-Wave devices page 117 state a 30 day trial may be recommended "and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS)." The medical reports provided do not show the patient has received physical therapy medication therapy and treatment with a TENS unit. In this case, there is no evidence of functional improvement from a prior H-Wave home trial and no documentation of failure of conservative care including physical therapy, medications and TENS. The current request does not satisfy the MTUS guidelines as outlined on pages 117-118. The current request is not medically necessary.

Lumbar Corset (Indefinite Use) QTY: 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 5th Edition, 2007, Low Back - Supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Lumbar Support.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Home H-Wave Unit Device (Infinite Use) QTY: 1. The treating physician report dated 9/25/15 (26B) notes that the patient presents with low back pain. The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding lumbar supports: "Recommended as an option for compression fractures and specific treatment of spondylo-lysthes, documented instability, and for treatment of nonspecific LBP." In this case, the patient presents with chronic low back pain and a back brace is being requested in order to help provided relief for the patient's symptoms. Furthermore, the back brace will provide the patient with some lateral support and stability. The current request satisfies the ODG guidelines as outlined in the "Low Back" chapter. The current request is medically necessary.