

<b>Case Number:</b>	CM15-0057343		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	10/07/2011
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 was a 64 year old female, who sustained an industrial injury, October 7, 2011. The injured worker previously received the following treatments lumbosacral x-rays 5 views, lumbar spine CT scan, lumbar spine MRI, back surgery April 20, fusion of L4-L5 and L5-S1, 2012, Hydromorphone, Cyclobenzaprine, Naproxen, Omeprazole, Amitriptyline, Diazepam, Fluticasone, Famotidine and H-wave electrical stimulator. The injured worker was diagnosed with low back pain, lumbar discogenic pain syndrome, lumbar radiculitis, lumbar post laminectomy syndrome, lumbar facet joint pain, myalgia and chronic pain syndrome. According to progress note of January 14, 2015, the injured workers chief complaint was elevated low back pain. The injured worker was unable to tolerate the lower dose of medication. The injured worker described the pain as diffuse aching type pain with occasional stabbing sensation with persistent muscle tightness from the lumbosacral area into the gluteals. The pain was aggravated by sitting, bending, lifting, standing or walking. The pain was better with medications, lying down and ice. The injured worker rated the pain 10 out of 10 without pain medication and 5-9+ with pain medication; 0 being no pain and 10 being the worse pain. The injured worker was receiving great relief from the H-wave treatments. The physical exam noted tenderness over the lower lumbar paraspinals at L4-L5 and L5-S1 facet joints bilaterally with decreased range of motion. There were diffuse muscle spasms with related myofascial restrictions. The treatment plan included a prescription for Ultra gel and H-wave supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultra gel #3 bottles (3 month supply) purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Ultra Gel #3, CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the documentation available for review, none of the abovementioned criteria have been documented and the specific active ingredients of the requested gel have not been clearly identified. In the absence of clarity regarding the above issues, the requested Ultra Gel #3 is not medically necessary.

**H Wave electrodes #36-9 packs of 4 (3month supply) purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114, 117-118 of 127.

**Decision rationale:** Regarding the request for H-wave electrodes, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-wave stimulation 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation available for review, it is noted that the patient has been utilizing H-Wave, but there is no indication that the patient previously failed a one-month TENS unit trial as recommended by guidelines. Furthermore, there is no indication of the outcome of any prior H-Wave trial/use in terms of quantified pain relief, objective functional improvement, and/or decreased medication usage to support the medical necessity of additional electrodes. In the absence of such documentation, the currently requested H-wave electrodes are not medically necessary.