

Case Number:	CM13-0017171		
Date Assigned:	10/11/2013	Date of Injury:	11/02/2003
Decision Date:	01/07/2014	UR Denial Date:	07/26/2013
Priority:	Standard	Application Received:	08/27/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in physical medicine and rehabilitation, and is licensed to practice in California. 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 physician 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/services.

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 patient is a 36-year-old who reported a work-related injury on 11/02/2003 as result of a fall. The patient presents for treatment of the following diagnoses: low back pain, lumbosacral neuritis, displacement of internal disc, facet syndrome, and chronic pain syndrome. The clinical note dated 06/04/2013 reported the patient was seen under the care of [REDACTED]. The provider documents the patient presents status post radiofrequency treatment to the lumbar spine. The provider documents the patient reports 2/10 pain to the lumbar spine. The patient utilizes the following medications for his pain complaints, hydrocodone/acetaminophen 10/500 mg, omeprazole, Topamax, and tizanidine. The provider documented upon physical exam of the patient, less tenderness for straight leg raise on the right side with more palpable tenderness on the left. Slight spasms were noted to the lumbar spine on the left as well. The patient had less of a kyphotic gait. The provider documented the patient presented with improved lumbar mechanical pain to the right side with some residual pain noted to the left. The provider documented the patient would be treated conservatively.

IMR ISSUES, DECISIONS AND RATIONALES

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

One home H-Wave device: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

Decision rationale: The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, H-wave stimulation is not recommended as an isolated intervention. The clinical documentation submitted for review reports the patient has utilized an H-wave trial for his pain complaints. The document dated 07/10/2013 reports the patient utilized 107 days of H-wave. The clinical notes document the patient reported increased daily activities and decreased medication and had previously utilized physical therapy, medications and injections. However, the Chronic Pain Medical Treatment Guidelines indicates the clinical notes failed to evidence significant objective findings of symptomatology to support purchase of the requested durable medical equipment at this point in the patient's treatment. The patient presented with reports of pain at 2/10 to 4/10. In addition, the clinical notes lack evidence of the patient having recently utilized active treatment modalities for his pain complaints such as supervised therapeutic interventions. The request for one home H-wave device is not medically necessary or appropriate.