MAXIMUS Federal Services

Case Number:	CM14-0005289		
Date Assigned:	01/24/2014	Date of Injury:	05/05/2000
Decision Date:	06/09/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	01/14/2014

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. The expert reviewer is Board Certified in Anesthesiology, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 49 year old male with a report of a fall injuring the low back and left lower extremity occurring on 05/05/2000. A clinical note dated 10/23/13 indicated a urine drug screen demonstrated compliance with the prescribed drug regimen. A clinical note dated 11/13/13 indicated the patient complaining of chronic weakness in the right lower extremity. The patient had been utilizing an Ankle Foot Orthotic brace as an intervention. There was an indication of continued complaints of shortness of breath following a left thoracotomy secondary to removal of a benign infection of a lung mass on 04/29/13. The record indicates a previous epidural steroid injection with a 70% improvement. The patient underwent L5-S1 fusion with L4-5 disc replacement and subsequent L4-5 fusion in 01/10. The patient underwent a trial of a spinal cord stimulator in 03/13 with a resultant 50% improvement in leg and back pain. The patient continued to rate his pain as 6-10/10. A clinical note dated 12/18/13 indicated the patient utilizing H-wave unit at home.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUE USAGE OF H-WAVE UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

H-WAVE UNIT SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

Decision rationale: The clinical documentation indicates the patient complaining of ongoing low back pain with associated lower extremities weakness. According to the MTUS Chronic Pain Guidelines, the use of an H-wave unit is indicated provided that the patient meets specific criteria, including completion of all conservative treatment and the demonstration of objective functional improvement through the initial course of treatment. The clinical notes indicate the patient uses the H-wave unit to address low back complaints. However, no objective data was submitted confirming positive response. Given the lack of documented functional improvement, the request is not medically necessary and appropriate.