

Case Number:	CM14-0007360		
Date Assigned:	02/10/2014	Date of Injury:	11/17/2005
Decision Date:	06/09/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/21/2014

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 Orthopedic Surgery, 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 69 year old male whose date of injury is 11/17/2005. On this date his chair broke causing him to fall backwards against a wall. The injured worker complained of neck pain, low back pain, right shoulder pain and right knee pain. Progress note dated 07/29/13 indicates that the injured worker is being followed for neck and low back pain. Psychiatric interim report dated 01/08/14 indicates that the injured worker has been treated for diagnosis of major depression, severe, and psychological factors affecting medical condition. He has been more stable regarding depression and anxiety with individual psychotherapy and current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT), Page(s): 117.

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

Decision rationale: Based on the clinical information provided, the request for H-wave unit is not recommended as medically necessary. There is no comprehensive assessment of treatment

completed to date or the patient's response thereto submitted for review. There is no indication that the injured worker has undergone a successful trial of H-wave to establish efficacy of treatment. There is no current, detailed physical examination submitted for review, and no specific, time-limited treatment goals are provided. There is no indication that the unit will be used as an adjunct to a program of evidence-based functional restoration, as required by CA MTUS guidelines.

ELECTRODES #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT), Page(s): 117.

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

Decision rationale: Based on the clinical information provided, the request for electrodes #12 is not recommended as medically necessary. Given that the request for H-wave unit is not considered medically necessary, the request for electrodes is not supported.

CONDUCTIVE GEL/PASTE #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT), Page(s): 117.

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

Decision rationale: Based on the clinical information provided, the request for conductive gel/paste #1 is not recommended as medically necessary. Given that the request for H-wave unit is not considered medically necessary, the request for conductive gel/paste #1 is not supported.