

Case Number:	CM14-0013148		
Date Assigned:	02/24/2014	Date of Injury:	09/21/2013
Decision Date:	07/15/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/31/2014

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 Internal Medicine, 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 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 51 year old male whose date of injury is 09/21/13. The mechanism of injury is described as lifting heavy luggage. Progress report dated 12/11/13 indicates that the injured worker presents for follow-up of lumbosacral muscle strain. The injured worker completed a course of physical therapy. He tried chiropractic treatment with no long-term benefit. Progress report dated 01/07/14 indicates that diagnoses are lumbosacral strain and lumbar radiculopathy. Note dated 01/16/14 indicates that he has been using a TENS unit at physical therapy with improvement of his symptoms. Lumbar MRI dated 01/24/14 revealed mild degenerative disc disease of the lower lumbar spine; L3-4 mild bulge and mild right neural foraminal narrowing; and L4-5 mild bulge with facet arthrosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR H-WAVE UNIT FOR HOME USE QUANTITY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) H-wave stimulation (devices).

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 lumbar H-wave unit for home use is not recommended as medically necessary. Chronic Pain Medical Treatment Guidelines require failure of conservative treatment including a TENS unit prior to a trial of H-wave stimulation. The submitted records indicate that the injured worker had a positive response to TENS in physical therapy. There is no indication that the injured worker has undergone a successful trial of H-wave to establish efficacy of treatment in accordance with Chronic Pain Medical Treatment Guidelines. There are no specific, time-limited treatment goals provided. The request is not medically necessary and appropriate.