MAXIMUS Federal Services

Case Number:	CM14-0019543		
Date Assigned:	04/23/2014	Date of Injury:	11/05/2009
Decision Date:	07/03/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/17/2014

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 Family Practice and is licensed to practice in California, Tennessee, and Virginia. 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 71 year old male whose date of injury is 11/05/09. The injured worker reports a repetitive activity work-related injury. Progress report dated 02/21/14 indicates that the injured worker presents for follow up of abdominal pain rated as 2/10. He also complains of low back pain rated as 4-5/10. The injured worker has reportedly failed a home exercise program and Transcutaneous Electrical Nerve Stimulation (TENS) unit trial. Medications are listed as Butrans patch and ibuprofen. On physical examination strength is rated as 5-/5. He has pain across the lower back with no radicular complaints. Deep tendon reflexes are 1+ at bilateral knees. There is no sensory deficit. There is decreased light touch sensation S1 dermatome on the right. Letter from the injured worker dated 02/24/14 indicates that he has utilized an H-wave unit. The injured worker states that his back feels more relaxed and pain is reduced approximately 25-30%.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE TRIAL: Upheld

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

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 trial 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. The patient has reportedly undergone a previous trial of H-wave and reports subjective pain relief; however, there are no objective measures of improvement documented to establish efficacy of treatment as required by California Medical Treatment Utilization Schedule guidelines. There are no specific, time-limited treatment goals provided.