

Case Number:	CM14-0117790		
Date Assigned:	08/06/2014	Date of Injury:	08/21/2001
Decision Date:	09/10/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	07/25/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 58-year-old female who was reportedly injured on 8/21/2001. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated 6/3/2014, indicated that there were ongoing complaints of chronic low back pain. The physical examination demonstrated lumbar spine limited range of motion, positive tenderness to palpation of the paralumbar muscles with spasms noted from L2-L5 and S1. There were bilateral sacroiliac and trochanteric tenderness. No recent diagnostic studies are available for review. Previous treatment included transcutaneous electrical nerve stimulation unit, acupuncture and medications. A request was made for home H-wave device and was not certified in the pre-authorization process on 7/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Device: Upheld

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

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

Decision rationale: California Medical Treatment Utilization Schedule guidelines will support HWT (H-Wave Stimulation) greater than one month justified with documentation submitted for review. While H-Wave and other similar type devices can be useful for pain management, they are most successfully used as a tool in combination with functional improvement. The injured worker has chronic low back pain. Review of the medical records fails to document improvement in function or decrease in pain with one month trial of H wave device. Without further justification from the treating physician, this request is not considered medically necessary.