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| Case Number: | CM14-0021128 | | |
| Date Assigned: | 05/07/2014 | Date of Injury: | 04/17/2003 |
| Decision Date: | 07/09/2014 | UR Denial Date: | 02/04/2014 |
| Priority: | Standard | Application Received: | 02/20/2014 |

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 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 64 year old male whose date of injury is 04/17/2003. The injured worker was lifting a tool overhead when he felt right shoulder and low back pain. Treatment to date includes anterior cervical discectomy and fusion at C4-5 and C5-6, physical therapy, right shoulder arthroscopy on 03/18/11, diagnostic testing and medication management. Lumbar MRI dated 06/04/13 revealed circumferential disc bulging throughout the lumbar spine. The injured worker underwent trigger point injections on 11/04/13 and 12/05/13. Follow up note dated 01/09/14 indicates that lumbar motion is restricted. There is muscle spasm present. H-wave report dated 05/06/14 indicates that H-wave provided 50% subjective pain relief.

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 Chronic Pain Medical Treatment Guidelines H-wave stimulation.

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. The injured worker underwent a trial of H-wave and

reported subjective pain relief; however, there are no objective measures of improvement provided to establish efficacy of treatment. There are no specific, time-limited treatment goals provided as required by California Medical Treatment Utilization Schedule (CAMTUS) guidelines. There is no documentation that the unit is being utilized as an adjunct to a program of evidence-based functional restoration.