

Case Number:	CM14-0022155		
Date Assigned:	05/09/2014	Date of Injury:	09/26/2000
Decision Date:	07/10/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/21/2014

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 Neurological Surgery 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 64-year-old male whose date of injury is 09/26/2000. The mechanism of injury is not described. The treatment to date includes cervical fusion in 2001 and 2003, history of bilateral knee surgery, lumbar decompressive surgery in 2005, lumbar fusion in 2009 and 2013, physical therapy and medication management. A progress note dated 04/17/14 indicates that the injured worker has back pain and ambulates with a cane. He continues to use an H-wave unit. He reports subjective pain relief, but is still taking the same amount of medication. The unit does not allow him to participate in longer sitting, standing or housework.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE RENTAL FOR ONE (1) MONTH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118. Decision based on Non-MTUS Citation ACOEM GUIDELINES, 2ND EDITION, CHAPTER 12, PAGE 300; ACOEM GUIDELINES, CHRONIC PAIN CHAPTER (REVISED 08/08/2008), H-WAVE STIMULATION, PAGE 189 AND THE OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK CHAPTER; PAIN CHAPTER, H-WAVE STIMULATION.

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

Decision rationale: Based on the clinical information provided, the request for Home H-wave device rental for one (1) month is not recommended as medically necessary. The submitted records indicate that the injured worker continues to use an H-wave unit. He reports subjective pain relief, but is still taking the same amount of medication. The unit does not allow him to participate in longer sitting, standing or housework. Given the lack of objective measures of improvement with use of an H-wave, efficacy of treatment is not established in accordance with the Chronic Pain Guidelines, and the requested H-wave trial is not supported as medically necessary. There are no specific, time-limited treatment goals provided.