

Case Number:	CM14-0023880		
Date Assigned:	09/10/2014	Date of Injury:	06/12/2008
Decision Date:	10/16/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/25/2014

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 Anesthesiology, has a subspecialty in Pain 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 56 year old female whose date of injury is 06/12/2008. The mechanism of injury is described as a fall when coming from a laundry facility. Treatment to date includes left hip arthroscopy in 2011, left hip steroid injection, physical therapy, pain program and medication management. The injured worker was authorized for an H-wave trial on 02/17/14. Diagnoses are left hip pain, osteoarthritis, lumbar degenerative disc disease, adjustment disorder with depression and anxiety, and chronic pain syndrome. Follow up note dated 07/21/14 indicates that activity level has remained the same. Medications include Celebrex, Cymbalta, Robaxin, Norco, and lorazepam.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Unit, Unspecified Rental Or Purchase For The Lower Back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HTW).

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, unspecified rental or purchase for the lower back is not recommended as medically necessary.

The request is nonspecific. The injured worker has been authorized for a prior trial of H-wave; however, the injured worker's objective, functional response to the trial is not documented to establish efficacy of treatment as required by CA MTUS guidelines. There are no specific, time-limited treatment goals provided in accordance with CA MTUS guidelines.