

Case Number:	CM14-0025265		
Date Assigned:	06/11/2014	Date of Injury:	10/04/2005
Decision Date:	07/15/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/27/2014

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, has a subspecialty in Pain Medicine 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 51-year-old female who reported an injury on 10/04/2005. The mechanism of injury was noted to be a rear-ended accident. Her diagnosis was noted to be lumbar sprain/strain with radiculopathy. The injured worker's previous treatments were noted to be physical therapy, TENS, and medications. The most recent clinical evaluation submitted with this review was on 01/09/2014. The injured worker complained of constant low back pain rated 7/10; she indicated that the pain disrupted her sleep. She also indicated leg and hip pain rated 5/10 which was intermittent and also disturbed her sleep. A physical evaluation was not found within this date of service. There is a treatment plan, however. The injured worker is to continue with medication, including Lorzone and Butrans patch. The injured worker will remain off work until 03/01/2014. The Request for Authorization of Medical Treatment is dated 01/21/2014. The provider's rationale for the requested services was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

THREE ADDITIONAL MONTHS RENTAL HOME H-WAVE DEVICE LUMBAR:

Upheld

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

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

Decision rationale: The request for three additional months rental home h-wave device lumbar is non-certified. In the most recent clinical evaluation, there is no indication that the injured worker is using an H-wave device. It is indicated that the patient is using medications and they are effective for symptom control. The California MTUS Chronic Pain Medical Treatment Guidelines indicate H-wave is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electric nerve stimulation, or TENS. If the injured worker has been using an H-wave system, it is not indicated in the most recent progress report. The guidelines continue to state that trial periods of more than 1 month should be justified by documentation submitted for review. There are no such documents provided within this review to indicate justification for continuing an H-wave system. Therefore, the request for three additional months rental home h-wave device lumbar is not medically necessary.