MAXIMUS Federal Services

Case Number:	CM15-0042687		
Date Assigned:	03/12/2015	Date of Injury:	03/12/2014
Decision Date:	04/16/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, Illinois
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 44 year old male, who sustained a work/ industrial injury on 3/12/14. He has reported initial symptoms of mid back pain rated 7/10. The injured worker was diagnosed as having thoraco/lumbosacral neuritis. Treatments included medication, Transcutaneous Electrical Nerve Stimulation (TENS) unit, acupuncture, and physical therapy. Currently, the injured worker complains of chronic mid back pain.MRI reported L1-2 posterior ligamentous hypertrophy, L2-3 disc protrusion, L4-5 disc protrusion, moderate spinal stenosis; and L5-S1 disc space narrowing, disc protrusion which bulges. The treating physician's report (PR-2) from 2/11/15 indicated the injured worker was not sufficiently improved with conservative care. The injured worker complained of pain and impaired activities of daily living (ADL's). Medications included Flexeril, Norco, and Naproxen. Diagnosis was lumbar radiculopathy with L4-5 disc protrusion. Treatment plan included referral for pain management and H-Wave unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines HWave, Transcutaneous Electrotherapy.

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

Decision rationale: The injured worker sustained a work related injury on 3/12/14. The medical records provided indicate the diagnosis of thoraco/lumbosacral neuritis. Treatments included medication, Transcutaneous Electrical Nerve Stimulation (TENS) unit, acupuncture, and physical therapy. The medical records provided for review do not indicate a medical necessity for: H-Wave unit purchase. The MTUS does not recommend the use of : H-Wave unit as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive 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 electrical nerve stimulation (TENS). There is no indication the injured worker has been enrolled in an evidence based functional restoration program.