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| Case Number: | CM15-0044401 | | |
| Date Assigned: | 03/16/2015 | Date of Injury: | 03/12/1999 |
| Decision Date: | 04/16/2015 | UR Denial Date: | 02/20/2015 |
| Priority: | Standard | Application Received: | 03/09/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 male, who sustained an industrial injury on March 12, 1999. The injured worker had reported a back injury. The diagnoses have included lumbago, displacement of lumbar disc without myelopathy, degenerative lumbosacral intervertebral disc and thoracic/lumbosacral radiculitis. Treatment to date has included medications and an MRI of the lumbar spine. Current documentation dated January 28, 2015 notes that the injured worker complained of low back pain, bilateral foot pain and bilateral foot numbness. Physical examination revealed a painful and decreased range of motion in all directions. Examination of the lower extremities revealed the strength to be four/five. The injured worker was noted to have an antalgic gait. The treating physician's recommended plan of care included an H-Wave Unit.

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 TENs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT), p117 Page(s): 117.

Decision rationale: The claimant has a remote history of a work injury occurring in 1999 and continues to be treated for chronic low back and bilateral lower extremity pain with lower extremity numbness. On the date of service, physical examination findings included an antalgic gait. Additional testing was planned. Guidelines recommend that a one-month home-based trial may be considered as a noninvasive conservative option. In this case, the claimant has not undergone a home-based trial of H-wave stimulation and therefore the requested H-wave unit for purchase is not medically necessary.