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| Case Number: | CM15-0049212 | | |
| Date Assigned: | 03/23/2015 | Date of Injury: | 07/09/2012 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 03/12/2015 |
| Priority: | Standard | Application Received: | 03/16/2015 |

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: California

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:

This 30 year old man sustained an industrial injury on 7/9/2012. The mechanism of injury is not detailed. Diagnoses include lumbar herniated nucleus pulposus status post-surgery, left sided sciatica, reactive depression, insomnia, low back pain, chronic pain syndrome, and lumbar radiculopathy. Treatment has included oral medications, home exercise program, and activity modification. Physician notes on a PR-2 dated 3/2/2015 show complaints of low back pain. Recommendations include purchase of H-wave system.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave device purchase quantity: 1.00: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 117-118.

Decision rationale: The one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be

documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Patient is currently working full time. He completed a one-month trial for the H-wave device and reported a decrease in pain and an increase in objective functional improvement. Use of device allowed for a decrease in medication levels. I am reversing the previous utilization review decision. A Home H-Wave device purchase is medically necessary.