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| Case Number: | CM14-0039180 | | |
| Date Assigned: | 06/27/2014 | Date of Injury: | 02/07/2013 |
| Decision Date: | 01/02/2015 | UR Denial Date: | 03/10/2014 |
| Priority: | Standard | Application Received: | 04/03/2014 |

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 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 59-year-old with date of injury 2/7/13. The injured worker was diagnosed with chronic low back pain due to sacroiliac joint dysfunction, lumbar stenosis and lumbar degenerative disease. Lumbar MRI revealed evidence of lumbar spondylosis and L4-5 broad-based disc protrusion. Treatment included physical therapy, electrotherapy with H wave, trigger point injections and lumbar facet joint injections and a plan for r radiofrequency ablation. The H wave device was noted to decrease pain and need for pain medications. Medications included Norco 10/325 mg as needed. On 2/24/14 request was made for purchase of 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 Device for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Work Loss Data Institute, LLC, www.odg-twc.com; Section: Low Back-Lumbar and Thoracic (Acute and Chronic) (Updated 02/13/14)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: The injured worker is being treated for chronic low back pain secondary to lumbar degenerative arthropathy. Progress note dated 2/24/14 indicates that the patient utilized an H wave device at home with subsequent decrease in the need for oral medication. The trial period length was not provided. MTUS guidelines recommend a one-month trial with a home-based H wave unit in order to document the frequency and outcomes of use. The documentation fails to provide duration and frequency of use at home. Request for H wave home device is therefore not medically necessary.