MAXIMUS Federal Services

Case Number:	CM13-0018961		
Date Assigned:	11/27/2013	Date of Injury:	08/06/2007
Decision Date:	01/21/2014	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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.

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 patient reported an injury on 01/16/2012. Notes indicate that the patient is status post lumbar interbody fusion at L3-4, L4-5, and L5-S1. The patient has previously been prescribed Naprosyn, Prilosec, Flexeril, Ultram, and ketoprofen cream. Notes indicate that a request was made for an H-Wave device purchase. A review of clinical notes submitted for 07/30/2013, 08/06/2013, and 09/03/2013, note that the patient has complaints of 2+ lumbar paraspinous muscle spasm with tenderness to palpation along the muscles, and tenderness to palpation of the bilateral sciatic notch. The patient's deep tendon reflexes were equal and symmetric at the knees and ankles, and motor strength was rated as 5/5 in all muscle groups of the bilateral lower extremities with negative straight leg raise sign bilaterally. Furthermore, treatment plan notes indicate that the patient was to treat his pain symptomatically with heat and that the patient was to start a pool therapy program.

IMR ISSUES, DECISIONS AND RATIONALES

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

purchase an H-Wave device: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section H-Wave Stimulation Page(s): 117.

Decision rationale: CA MTUS states that H-wave stimulation is not recommended as an isolated intervention, but that 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). There is a lack of documentation submitted for review indicating the patient has undergone an adequate trial with an H-wave device. Furthermore, there is a lack of documentation indicating that the patient has failed with other conservative treatments to include formal physical therapy, medications, or prior use of a transcutaneous electrical nerve stimulation unit. Given the above, the request for purchase of H-wave device is not medically necessary and appropriate.