

Case Number:	CM13-0030153		
Date Assigned:	03/03/2014	Date of Injury:	04/10/2006
Decision Date:	04/23/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/26/2013

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 Occupational Medicine and Internal Medicine, 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. 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:

According to the records made available for review, this is a 39-year-old male with a 4/10/06 date of injury. At the time (8/22/13) of request for authorization for home H-wave device one month for the back, there is documentation of subjective (low back pain and bilateral sciatica) and objective (decreased ROM, with direct palpation at the right L5 facet he has exquisite pain, FABER test is positive on the left) findings, current diagnoses (chronic lumbar spine pain, left sacroiliitis, and intermittent sciatica), and treatment to date (medication, PT, TENS, and a 45 minute trial with H-wave). There is no documentation of chronic soft tissue inflammation and that the H-wave will be used as an adjunct to a program of evidence-based functional restoration.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE ONE MONTH FOR THE BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section H-Wave Stimulat.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Section Low Back Complaints Page(s): 117-118.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identify documentation of chronic soft tissue inflammation and that the H-wave will be 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), as criteria necessary to support the medical necessity of H-wave. Within the medical information available for review, there is documentation of diagnoses of chronic lumbar spine pain, left sacroiliitis, and intermittent sciatica. In addition, there is documentation of failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). However, there is no documentation of chronic soft tissue inflammation and that the H-wave will be used as an adjunct to a program of evidence-based functional restoration. Therefore, based on guidelines and a review of the evidence, the request for home H-wave device one month for the back is not medically necessary.