

Case Number:	CM13-0032307		
Date Assigned:	12/11/2013	Date of Injury:	08/04/2012
Decision Date:	05/19/2014	UR Denial Date:	09/03/2013
Priority:	Standard	Application Received:	10/07/2013

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, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 33-year-old male who reported an injury on 08/04/2012 after a motor vehicle accident. The injured worker's treatment history included physical therapy, medications, and a TENS unit trial. An evaluation after 120 days of use of an H-wave therapy unit documented on 08/13/2013 indicated that the injured worker had decreased medication usage, was able to walk farther, complete more housework, sit longer, and participate in prolonged activities with a 20% improvement with H-wave therapy use. A request was made for the purchase of a home H-wave stimulation device for the thoracic spine and left lower leg.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF A HOME H-WAVE STIMULATION DEVICE FOR THE THORACIC AND LEFT LOWER LEG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The requested home H-wave stimulation device for purchase for the thoracic and left lower leg is not medically necessary or appropriate. The California Medical Treatment

Utilization Schedule does not support the use of H-wave stimulation as a standalone treatment. The clinical documentation submitted for review does not provide any recent evidence that the injured worker is participating in an active functional restoration program that would benefit from an adjunct therapy such as H-wave stimulation. The clinical documentation submitted for review did not provide a recent evaluation by the treating provider with objective physical findings of improvements as a result of the trial of an H-wave stimulation device. Therefore, the purchase of an H-wave stimulation device is not supported. As such, the requested home H-wave stimulation device for purchase for the thoracic and left lower leg is not medically necessary or appropriate.