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| Case Number: | CM13-0035207 | | |
| Date Assigned: | 12/13/2013 | Date of Injury: | 05/13/2009 |
| Decision Date: | 10/29/2014 | UR Denial Date: | 10/02/2013 |
| Priority: | Standard | Application Received: | 10/16/2013 |

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 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 65-year-old male who reported an injury on 05/13/2009. The mechanism of injury was not provided. The injured worker's diagnoses included active left S1 radiculopathy, escalating axial discogenic mechanical low back pain, status post lumbar fusion, cervical myoligamentous sprain/strain, symptomatic degenerative tricompartmental osteoarthritis bilateral knees, status post left and right knee arthroplasty, bilateral wrist carpal tunnel syndrome, and right cubital tunnel syndrome. The injured worker's past treatments included medications, H wave unit, physical therapy, and surgery. The injured worker's diagnostic testing included official x-rays of the lumbosacral spine on 06/20/2013, which indicated fusion of T12-S1 and mild increasing ossification of the osseous home graft material. The injured worker's surgical history included lumbar fusion on 03/05/2013, left knee arthroplasty on 02/02/2011, and right knee arthroplasty on 08/24/2011. On the clinical note dated 08/20/2013, the injured worker complained of pain, swelling, and stiffness rated 7/10 in the low back and knee before H wave treatment and 4/10 to 5/10 after H wave treatment. The injured worker had limited range of motion before H wave treatment to the low back and knee and had increased ability to function afterwards. The injured worker's medications included pain medications, anti-inflammatory medications, and muscle relaxants. The names, dosages, and frequencies were not provided. The request was for purchase of home H wave device. The rationale for the request was not provided. The Request for Authorization form was submitted on 08/15/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of home H-Wave device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave stimulation.

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

Decision rationale: The request for Purchase of home H-Wave device is not medically necessary. The injured worker is diagnosed with active left S1 radiculopathy, escalating axial discogenic mechanical low back pain, status post lumbar fusion, cervical myoligamentous sprain/strain, symptomatic degenerative tricompartmental osteoarthritis bilateral knees, status post left and right knee arthroplasty, bilateral wrist carpal tunnel syndrome, and right cubital tunnel syndrome. The injured worker complained of low back pain and knee pain rated 7/10 before H wave therapy and 4/10 to 5/10 after H wave therapy. The California MTUS does not recommend an H wave unit as an isolated intervention, but does recommend for a 1 month home based trial. H wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used in an adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation, or TENS. The 1 month home H wave therapy trial may be appropriate to permit the physician and provider license to provide physical therapy to study the effects and benefit, 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. Trial periods of more than 1 month should be justified by the documentation submitted for review. The injured worker's medical records indicated the injured worker tried the H wave unit on 08/20/2013. The medical records indicate the injured worker has exhausted his allowable physical therapy and will be utilizing a home exercise kit. The injured worker's medical records lack documentation of a trial of a TENS unit. The request is for purchase of the home wave unit, whereas the guidelines recommend a 1 month trial. The requesting physician did not provide documentation of an adequate and complete assessment of the injured worker's pain efficacy with the unit. The injured worker's medical records lack documentation of current objective functional deficits and pain status. Additionally, the request does not indicate the site of application, frequency, or length of usage of the H wave unit. As such, the request for Purchase of home H-Wave device is not medically necessary.