

Case Number:	CM13-0047424		
Date Assigned:	12/27/2013	Date of Injury:	01/09/2003
Decision Date:	04/18/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	11/01/2013

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 50-year-old male who sustained an industrial injury on 01/09/2003. The mechanism of injury was not provided. His diagnoses include chronic low back pain- s/p multiple fusions, lumbar radiculopathy, cervical discogenic disc disease- s/p cervical fusion C4-C7, cervical radiculopathy, thoracic discogenic disc disease, right shoulder impingement syndrome with tendonitis, right wrist De Quervain tenosynovitis and arthritis of the right hand. He complains of neck and bilateral arm pain with numbness, right shoulder and wrist pain, and low back pain. On exam, there is spasm of the cervical spine with decreased range of motion, radiculopathy on the right at C5-C7, and decreased sensation on the right at C5-C7. Exam of the right shoulder reveals a positive impingement sign with painful range of motion. His forward flexion is to 160 degrees and abduction to 100 degrees. Examination of the lumbar spine reveals a healed surgical incision, lumbar spasm and decreased range of lumbar motion. There is decreased sensation on the right at L4-L5 and L5-S1. Motor exam is intact bilaterally and straight leg raising is negative bilaterally. Exam of the right wrist reveals a positive De Quervain and positive grip strength on the right. Treatment has included medical therapy and use of an H Wave unit. The treating provider has recommended 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:

DME: H-WAVE PURCHASE: 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 Page(s): 117.

Decision rationale: H Wave stimulation is not recommended as an isolated intervention. 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). A positive response was reported with use of the unit but there is no specific documentation of increased functional status or decreased use of medication for pain control. Given the records provided for review, medical necessity for the requested item has not been established. The requested treatment is not medically necessary.