

Case Number:	CM13-0050788		
Date Assigned:	12/27/2013	Date of Injury:	02/15/2010
Decision Date:	05/30/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/13/2013

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 59-year-old male who reported an injury on 02/15/2010. The mechanism of injury was not stated. The current diagnoses include lumbar disc syndrome, sciatica, grade 1 spondylolisthesis, bilateral foraminal stenosis, bilateral shoulder sprain, bilateral elbow sprain, and bilateral wrist sprain. The injured worker was evaluated on 09/11/2013. The injured worker reported 10/10 pain over multiple areas of the body. The injured worker has been previously treated with three (3) epidural steroid injections into the lumbar spine. A physical examination revealed an antalgic gait, limited lumbar range of motion, positive straight leg raising bilaterally, 4/5 motor strength in the bilateral lower extremities, and lumbar spasm. The treatment recommendations at that time included an H-wave home unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The Chronic Pain Guidelines indicate that H-wave stimulation is not recommended as an isolated intervention, but a one (1) month home based trial may be considered as a noninvasive conservative option. H-wave stimulation should be used as an addition to a program of evidence based functional restoration and only following a failure of initially recommended conservative care. There is no documentation of a failure to respond to physical therapy, medications, or TENS therapy. There is also no mention of this injured worker's active participation in a functional rehabilitation program to be used in conjunction with the H-wave stimulator unit. There is no evidence of a successful one (1) month trial prior to the request for a unit purchase. Based on the clinical information received, the request is non-certified.