

Case Number:	CM14-0009188		
Date Assigned:	02/14/2014	Date of Injury:	07/24/2012
Decision Date:	07/24/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/23/2014

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 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:

The patient is a 59-year-old male who has submitted a claim for multilevel lumbar disc protrusions and facet arthropathy, L3-L5 central foraminal stenosis, and lower back pain with right lumbar radicular pain associated with an industrial injury date of 07/24/2012. Medical records from 10/15/2012 to 12/19/2013 were reviewed and showed that the patient complained of persistent low back pain (grade not specified). Radiation of pain down the right leg was decreased. Physical examination revealed tenderness to palpation over the right side of the lower lumbosacral spine. SLR test was positive in the right leg for radicular pain. MMT and sensory to light touch was intact for bilateral lower extremities. MRI of the lumbar spine dated 11/09/2012 revealed L3-S1 multiple disc protrusions, L3-5 facet hypertrophy, and L3-5 foraminal stenosis. Treatment to date has included physical therapy, lumbar facet injection, translumbar epidural injection, diclofenac sodium, tramadol, and Voltaren gel. Utilization review, dated 01/03/2014, denied the request for H-wave device, one month home evaluation use because there was no indication that the patient has a HEP or a trial of TENS unit.

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 HOME USE EVALUATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy,H-Wave Page(s): 114-118.

Decision rationale: According to pages 114-118 of the California MTUS Chronic Pain Treatment Guidelines, a one-month home-based trial of H-wave stimulation may be indicated with chronic soft tissue inflammation and when H-wave therapy will be used as an adjunct to a method of functional restoration. It is only recommended following failure of initial conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). In this case, there was no documentation of active participation of functional restoration such as HEP (home exercise program) or failure to respond to conservative management. The guidelines do not recommend H-wave device treatment as an isolated intervention. Therefore, the request for Home H-Wave Device, One Month Home Use Evaluation is not medically necessary.