

Case Number:	CM14-0011605		
Date Assigned:	02/21/2014	Date of Injury:	03/21/2006
Decision Date:	07/03/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	01/29/2014

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 53-year-old male who reported an injury on 03/21/2006 after a slip and fall. The injured worker reportedly sustained an injury to his low back, left wrist, neck, right shoulder, and suffered headaches. The injured worker's treatment history included physical therapy, medications and a TENS unit. The injured worker was evaluated on 06/25/2013. Physical findings included restricted cervical spine range of motion secondary to pain and restricted range of motion of the lumbar spine secondary to pain. The injured worker had a bilateral positive straight leg raising test. The injured worker's diagnoses included anxiety, chronic opioid pain dependency, bilateral hearing decline, constipation, gastrointestinal dysphagia to liquids, erectile dysfunction, occasional testicular pain, and postlaminectomy syndrome of the cervical spine. The injured worker's treatment plan included a 30 day clinical trial of an H-wave unit. The injured worker was evaluated on 01/07/2014. It was documented that the injured worker had recently began using the H-wave therapy unit that provided significant pain relief and allowed for discontinuation of all medications. A request was made for the purchase of an H-wave therapy 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 CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrostimulation Page(s): 113-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT), page(s) 117 Page(s): 117.

Decision rationale: The requested home H-wave device for the cervical spine is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker was authorized a 30 day home trial of this unit. It is noted within the documentation that the injured worker has received pain relief and has been able to discontinue all medications. However, the duration of the trial is not adequately addressed. Additionally, clinical documentation does not provide any evidence that the injured worker is currently participating in any type of active therapy that would benefit from this adjunctive treatment. Furthermore, the request as it is submitted does not specifically identify a treatment duration. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested home H-wave device cervical spine is not medically necessary or appropriate.