MAXIMUS Federal Services

Case Number:	CM14-0018124		
Date Assigned:	04/16/2014	Date of Injury:	01/10/2010
Decision Date:	06/04/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/12/2014

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 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 51-year-old female who reported an injury on 01/10/2010. The mechanism of injury was not stated. Current diagnoses include cervical disc disease with radiculitis, degeneration of the cervical discs, lumbosacral neuritis, low back pain, thoracic outlet syndrome and hypertension. The latest Physician's Progress Report submitted for this review is documented on 12/12/2013. The injured worker reported neck pain and stiffness with radiation along the left upper extremity as well as lower back pain with radiation to the left lower extremity. The injured worker has completed 20 sessions of physical therapy. The injured worker was also 3 weeks status post an epidural steroid injection. Physical examination on that date revealed a non-antalgic gait, restricted range of motion of the lumbar spine with muscle guarding, full range of motion of the cervical spine with muscle guarding, trigger points along the trapezius and upper back muscles, diminished strength in the left upper extremity and decreased sensation to light touch in the C7 dermatome. Treatment recommendations included the continuation of current medications and a home exercise program. A previous Request for Authorization was submitted on 09/04/2013 for a 3 month trial of an H-wave home care system.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE FOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT), Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial may be considered as a noninvasive conservative option. H-wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following a failure of initially recommended conservative care. As per the documentation submitted, there was no indication of a failure to respond to physical therapy, medications or TENS therapy. There was also no mention of objective functional improvement following a 30 day trial prior to the request for a unit purchase. Therefore, the injured worker does not meet the criteria for the requested durable medical equipment. As such, the request is non-certified.