

Case Number:	CM14-0019179		
Date Assigned:	05/05/2014	Date of Injury:	07/03/2012
Decision Date:	07/09/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/14/2014

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 Illinois. 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 44 year old male who reported an injury on 07/03/2012 secondary to unknown mechanism of injury. The injured worker was evaluated on 10/17/2013 for reports of increased left flank and thoracolumbar pain. The injured worker reported a muscle spasm in the left flank and thoracolumbar area rated at 6/10 on the visual analog scale. The exam noted palpable tenderness of the lumbar paraspinous incision and left flank and thoracolumbar region. The lumbar spine range of motion was noted to be at 21 degrees for extension, 11 degrees for left lateral bend, and 24 degrees right lateral bend. The diagnoses included L3-4 and L4-5 disc herniation, left leg radiculopathy, left L3-4 stenosis, and status post L3-4 and L4-5 microdiscectomy and foraminectomy. The treatment plan included physical therapy and an H- wave unit to aid in the healing process and to decrease inflammation.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE DEVICE, PURCHASE FOR INDEFINITE USE, LOWER BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: The MTUS Chronic Pain Guidelines do not recommend a H-wave therapy as an isolated intervention, but a 1 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 initial recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. The exam did note an increase in the injured worker's pain level. However, there is a significant lack of objective evidence of chronic soft tissue inflammation and conservative therapies or a TENS trial. There is also no evidence of diabetic neuropathic pain in the documentation provided. Furthermore, the request is for purchase for indefinite use of an H-wave device, without evidence of a 1 month home based trial. Therefore, based on the documentation provided, the request is not medically necessary and appropriate.