MAXIMUS Federal Services

Case Number:	CM14-0156695		
Date Assigned:	09/26/2014	Date of Injury:	09/02/2012
Decision Date:	10/27/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/24/2014

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 Internal 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 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 patient is an injured worker with the diagnoses of lumbago, back disorder, and sacroiliitis. Injury date was 09/21/2012. Visit note dated August 28, 2014 documented subjective complaints of lower back and right buttock pain extending to her knee. Interval history included ice treatment, exercise, physical therapy she had 8-9 sessions in 2012 and chiropractic therapy she had 8-9 sessions in 2012. She is currently doing yoga at the gym at least twice a week. MRI of the lumbar spine without contrast performed 02/28/2013 documented mild disc bulges at L4-5 and L5-S1 with associated mild degenerative disc changes. Diagnoses were lumbago, back disorder, and sacroiliitis. Visit note dated June 25, 2014 documented that the patient had 0/10 pain. Physical examination was documented. Gait of the patient is normal. Examination of spine is normal and shows no limitation of movement or defect in curvature. Strength was 5/5 in all muscle groups. Sensation is intact to light touch and pinprick reflexes are equal and symmetric bilaterally in the upper and lower extremities. Babinski is negative. Cerebellar function grossly intact. Finger-to-nose coordination is within normal limits. Gait normal without ataxia. Treatment plan included physical therapy. Utilization review determination date was 8/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Home H-Wave Device between 8/26/2014 and 10/10/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines H-Wave stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308-310,Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Electrical stimulators (E-stim) Functional restoration progr. Decision based on Non-MTUS Citation ACOEM 3rd Edition. Bibliographic Source: Low back disorders. Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 333-796. Table 2: Summary of Recommendations by Low Back Disorder. Guideline.gov Work Loss Data Institute. Bibliographic Source: Work

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy and H-wave stimulation. MTUS Chronic Pain Medical Treatment Guidelines state that H-wave stimulation (HWT) is not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints, Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308-310) states that TENS is not recommended. ACOEM Chapter 12 (Page 300) states that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Work Loss Data Institute guidelines for Low Back - lumbar & thoracic (acute & chronic) state that TENS as an isolated intervention is not recommended, and that H-wave stimulation devices as an isolated intervention is not recommended. ACOEM 3rd edition (2011) states that H-wave stimulation is not recommended for low back disorders.Medical records do not document enrollment in a functional restoration program (FRP), which is a MTUS requirement for H-wave. Medical records do not document failure of conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). ACOEM 3rd edition (2011) states that H-wave stimulation is not recommended for low back disorders. MTUS, ACOEM, ODG, and Work Loss Data Institute guidelines do not support the medical necessity of H-wave electrotherapy for back conditions.Therefore, the request for Purchase of Home H-Wave Device between 8/26/2014 and 10/10/2014is not medically necessary.