

Case Number:	CM14-0027421		
Date Assigned:	06/13/2014	Date of Injury:	07/08/2008
Decision Date:	08/12/2014	UR Denial Date:	02/25/2014
Priority:	Standard	Application Received:	03/04/2014

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 & 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 67-year-old female who reported an injury on 07/08/2008. The mechanism of injury was not provided for clinical review. The diagnoses included disc herniation with moderate stenosis, moderate-sized disc herniation with significant foraminal stenosis, bilateral shoulder impingement, lateral epicondylitis, status post right carpal tunnel release, recurrent right carpal tunnel syndrome, left carpal tunnel syndrome, status post L3-5 lumbar interbody fusion, and disc desiccation throughout the lumbar spine. Previous treatments included TENS unit, medication, trigger point injections, surgeries, and physical therapy. Within the clinical note dated 09/24/2013, reported the injured worker complained of pain to the lower lumbar region, with pain increasing with activities such as lifting, bending, and stooping. The injured worker reported moderate to severe pain in the knees bilaterally. Upon the physical examination of the cervical spine, the provider noted muscle spasms at the cervical spine, and a positive Adson's test. The provider noted the range of motion of the lumbar spine was restricted to pain. The provider indicated the injured worker had spasms of the lumbar spine. The injured worker had a positive straight leg raise on the left in the sitting position and negative on the right in a sitting position. The most recent note dated 05/29/2014 was unchanged. The provider requested for an H-Wave for reduction of pain and reduction of medication intake. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

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

Decision rationale: The California MTUS Guidelines do not recommend the H-Wave as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathy, or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration; and only following the failure of initially recommended conservative care, including physical therapy and medication, plus transcutaneous electrical nerve stimulation. In this case, there is a lack of significant objective findings indicating the injured worker had any numbness or muscle weakness to suggest neuropathic pain. The clinical documentation indicated the injured worker had a trial of a TENS unit; however, there was a lack of documentation of the efficacy of the trial. The request submitted failed to provide whether the provider indicated the injured worker to purchase or rent the H-Wave device. Additionally, the length of duration was not provided in the request. The request submitted failed to provide a treatment site as well. Therefore, the request for a Home H-Wave device is not medically necessary and appropriate.