

Case Number:	CM14-0042359		
Date Assigned:	06/30/2014	Date of Injury:	12/04/2012
Decision Date:	08/20/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/08/2014

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 Nevada. 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 records, presented for review, indicate that this 55 year-old female was reportedly injured on 12/4/2012. The mechanism of injury was noted as a fall. The most recent progress note, dated 1/22/2014, indicated that there were ongoing complaints of low back and upper back pains. The physical examination demonstrated thoracic spine positive tenderness to palpation paraspinal musculature and pain with range of motion. Lumbar spine had positive tenderness to palpation of paraspinal muscles bilaterally. No spasm noted. Limited range of motion was with pain. Negative straight leg raise. Bilateral lower extremity deep tendon reflexes 2+. No recent diagnostic studies were available for review. Previous treatment included acupuncture, Transcutaneous Electrical Nerve Stimulation (TENS) unit, medication, and conservative treatment. A request was made for home H-wave device (purchase) for the low back and was not certified in the pre-authorization process on 4/2/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of one Home H-Wave device for the low back: 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): 117-118 of 127.

Decision rationale: MTUS Guidelines will support a one-month HWT (H-Wave Stimulation) for diabetic neuropathic pain and chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following a failure of conservative treatment, physical therapy, medications and transcutaneous electrical nerve stimulation (TENS). Review of the available medical records failed to document the criteria required for the purchase of H-Wave Stimulation. As such, this request of purchase of one Home H-Wave device for the low back is not medically necessary and appropriate.