

Case Number:	CM14-0062942		
Date Assigned:	07/11/2014	Date of Injury:	05/05/2010
Decision Date:	08/26/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/05/2014

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 and Ohio. 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 69-year-old male who reported an injury on 05/05/2010. The mechanism of injury was a fall. His diagnoses include lumbar radiculopathy, bilateral knee sprain/strain, bilateral shoulder sprain/strain, and anxiety and depression. His past treatments were noted to include use of a back brace, participation in a home exercise program, medications, topical analgesics, and physical therapy. On 01/28/2014, the injured worker presented with complaints of low back pain and bilateral knee pain. He rated his pain 6/10 to 7/10. He also reported bilateral shoulder pain. His physical examination revealed decreased range of motion of the bilateral shoulders, tenderness to palpation over the thoracolumbar region with painful range of motion, and decreased motor strength and sensation in the left lower extremity in an L4-S1 distribution. His medications were noted to include topical analgesics. The treatment plan included continued use of the back brace, continued home exercise program, a 3 month trial of an H-wave unit, and topical analgesics. The rationale for the H-wave was to see how efficacious it would be in reducing his level of pain. The Request for Authorization Form was not submitted in the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Device Purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (BlueCrossBlueShield, 2007) (Aetna, 2005).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, page 117-118 Page(s): 117-118.

Decision rationale: According to the California MTUS Guidelines, H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave may be considered if used as an adjunct to a program of evidence based functional restoration, and only following the failure of initially recommended treatment, including physical therapy, medications, and use of a TENS unit. The clinical information submitted for review indicated that the injured worker was participating in a home exercise program. However, sufficient documentation showing evidence of a trial of physical therapy, medications, and use of a TENS unit was not submitted. In the absence of this documentation, use of an H-wave stimulation unit would not be supported. In addition, the purchase of an H-wave unit would not be supported unless documentation showed significant pain relief and increased function following a 1 month home-based trial. For the reasons noted above, the request is not medically necessary.