

Case Number:	CM14-0075122		
Date Assigned:	07/16/2014	Date of Injury:	02/15/2013
Decision Date:	08/25/2014	UR Denial Date:	05/12/2014
Priority:	Standard	Application Received:	05/23/2014

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 39-year-old male who reported an injury on 02/15/2013 due to a fall. On 06/10/2014, the injured worker presented with upper, mid, and low back pain. Examination of the lumbar spine noted range of motion values of 85 degrees/90 degrees of flexion, 30 degrees/30 degrees of extension, 30 degrees/30 degrees of bilateral rotation, 25/30 degrees of right bending, and 25/30 degrees of left bending. There was tenderness of the left sacroiliac joint, midline lumbar spine, and L1 to L5 with spasm bilaterally. The diagnosis were transverse fracture of the lumbar spine on left side from fall. Prior therapy included physical therapy, heat, massage, a TENS unit therapy, and medications. The provider recommended a home H-Wave device purchase for the left foot. The provider's rationale was not provided.

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 Left Foot: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Home Care Stimulator.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT), page(s) 117 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 painful neuropathy or 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 and medications, plus transcutaneous electrical nerve stimulation (TENS). An adequate examination of the injured worker's left foot was not providing detailing current deficits to warrant an H-Wave device. Additionally, as the Guidelines do not recommend an H-Wave device as an isolated intervention, and no other interventions are addressed as an adjunct to the H-Wave device, it would not be warranted. As such, the request for Home H-Wave Device Purchase Left Foot is not medically necessary.