

Case Number:	CM13-0012775		
Date Assigned:	12/18/2013	Date of Injury:	05/31/2009
Decision Date:	03/17/2015	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/19/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

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 (IW) is a 56 year old female who sustained an industrial injury to the low back and hip on 05/31/2009. She has reported pain in the low back and left hip. The diagnoses have included lumbar strain, progressive lumbar disc disease and discogenic pain, superimposed lumbosacral strain and sacroiliac strain with a history of pre-injury back pain. Treatment to date has included aqua therapies, Naproxen, hydrocodone and gabapentin. Currently, the IW complains of pain in the right lumbar regions, radiating pain to the left thigh and lateral leg. Symptoms are worsened with bending forward, bending backwards, or prolonged positioning. Examination of the lumbar spine noted a slight left low paraspinal and sacroiliac regional tenderness. Motion of the lumbar spine is 60 degrees of flexion, 15 degrees extension both associated with pain. There was no paraspinal spasm, or midline tenderness. Straight leg raise tests are negative; there is no reflex abnormality or asymmetry in either lower extremity. Gait, station and balance are normal. Patient has received an unspecified number of aqua therapy visits for this injury. She has had MRI of the lumbar spine on 2012 that revealed lumbar spine disc herniation; and spondylosis. The patient's surgical history include right shoulder arthroscopic surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE HOMECARE SYSTEM - PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT) Page(s): 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): Page 117-118.

Decision rationale: Request: H-WAVE HOMECARE SYSTEM – PURCHASE Per the CA MTUS Chronic Pain Medical Treatment Guidelines 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 diabetic neuropathic pain, 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS)." Per the records provided, any indications listed above were not specified in the records provided. The records provided did not specify any evidence of neuropathic pain, CRPS I and CRPS II. Any evidence of a trial and failure of a TENS for this injury was not specified in the records provided. Patient has received an unspecified number of aqua therapy visits for this injury. The records provided did not specify a response to conservative measures such as oral pharmacotherapy or splint in conjunction with rehabilitation efforts for this diagnosis. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of H-WAVE HOMECARE SYSTEM PURCHASE is not fully established for this patient.