

Case Number:	CM15-0100951		
Date Assigned:	06/03/2015	Date of Injury:	07/25/2005
Decision Date:	07/03/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/26/2015

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:

This is a 56 year old female patient who sustained an industrial injury on 7/25/05. Diagnoses include right knee strain and internal derangement, status post arthroscopy of the right knee (4/2/2014); left knee compensation; lumbar spine degenerative joint disease with possible herniated nucleus pulposus radiating discomfort. Per the doctor's note dated 4/30/2015, she had complaints of right knee pain, left knee pain and low back pain. physical examination of the lumbar spine revealed paraspinous tenderness, decreased range of motion; right knee- mild atrophy, medial and lateral joint line tenderness with a positive McMurray exam, patellofemoral exam-significant facet tenderness; left knee- negative McMurray test. The medications list includes motrin. Treatments to date include transcutaneous electrical nerve stimulator unit; medications; physical therapy. Diagnostics include x-ray of lumbosacral spine (no date) showing mild degenerative changes. In the progress note dated 4/30/15 the treating provider's plan of care includes authorization for a transcutaneous electrical nerve stimulator unit for purchase and H-wave is to follow. On 4/17/15 the treating provider requested purchase home H-wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Device for purchase for 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 Page 117-118H-wave stimulation (HWT).

Decision rationale: Request: Home H-Wave Device for purchase for low back. 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)." Evidence of diabetic neuropathy is not specified in the records provided. Evidence of failure of conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. Previous conservative therapy notes are not specified in the records provided. The medical necessity of a Home H-Wave Device for purchase for low back is not fully established for this patient at this juncture.