

Case Number:	CM15-0184844		
Date Assigned:	09/25/2015	Date of Injury:	06/06/2009
Decision Date:	11/03/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/21/2015

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: California

Certification(s)/Specialty: Emergency Medicine

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 64 year old female with a date of injury on 6-6-09. A review of the medical records indicates that the injured worker is undergoing treatment for chronic lumbar spine pain and bilateral knee pain. Progress report dated 8-6-15 reports continued complaints of lumbar pain and work related posttraumatic arthritis left knee. Upon exam, the left knee has swelling and tenderness, stable ligaments and crepitation noted. No significant change in lumbar spine. The injured worker use the home h-wave unit on a trial basis from 7-10-15 to 8-20-15 and reported more activity and greater overall function, feeling better and she could stand longer. Prior treatments include TENS unit, physical therapy, medication, home exercises, injections and surgery. X-ray of left knee revealed osteoarthritis present. Request for authorization dated was made for Home H-wave device (indefinite use) quantity 1. Utilization review dated 9-3-15 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave device (indefinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: As per MTUS Chronic pain guidelines H-Wave stimulation (HWT) is not recommended as an isolated therapy. It may be recommended in cases of diabetic neuropathy and chronic soft tissue inflammation with a successful 1-month trial if used as part of an evidence based functional restoration program. Patient does not even meet these basic criteria. Several criteria needs to be met before HWT may be recommended. 1) Failure of conservative therapy Fails criteria. Patient has noted ongoing conservative care. 2) Failure of TENS therapy Fails criteria. There is no documentation of failure. 3) Needs to be used as part of a functional restoration program, should not be used as an isolated treatment Fails criteria. There is no documentation of an actual functional restoration program or what the end goal of HWT is suppose to be. 4) Successful trial of HWT for 1month: Fails criteria. The providers are inappropriately claiming that patient's claimed improvement in pain are due to HWT trial when in fact patient has received injections within the claimed trial period. The HWT trial is not valid and fails criteria. There is not one single indication met to recommend this device. H-wave unit is not medically necessary.