MAXIMUS Federal Services

Case Number:	CM15-0023896		
Date Assigned:	02/13/2015	Date of Injury:	01/14/2012
Decision Date:	04/06/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/09/2015

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, Washington
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 42-year-old female who reported an injury on 01/14/2012. The mechanism of injury involved a fall. The current diagnosis is lumbosacral musculoligamentous strain. The latest physician progress report submitted for review is documented on 12/15/2014. The injured worker presented for an orthopedic evaluation. It was noted that the injured worker had been previously diagnosed with a kidney problem, for which she was taking a variety of medications. The injured worker reported persistence of low back symptoms. Upon examination, there was mild tenderness to palpation. There was no evidence of palpable muscle spasm. There was also no gross neurological deficit noted. Recommendations, at that time, included continuation of the home stretching exercises, as well as a refill of the current medication regimen. There was no Request for Authorization form submitted for this review.

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: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. H-wave stimulation should be used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care, including physical therapy, medications, and TENS therapy. In this case, there was no documentation of a significant musculoskeletal deficit. There is also no mention of a failure of conservative treatment to include physical therapy, medications and TENS therapy. The guidelines recommended a 1 month trial prior to the request for a unit purchase. As such, the request is not medically appropriate.