MAXIMUS Federal Services

Case Number:	CM15-0217641		
Date Assigned:	11/09/2015	Date of Injury:	06/22/2008
Decision Date:	12/21/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/05/2015

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: Physical Medicine & Rehabilitation

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 51 year old female, who sustained an industrial-work injury on 6-22-08. A review of the medical records indicates that the injured worker is undergoing treatment for status post right hip total hip replacement and lumbar spine strain and sprain. Treatment to date has included pain medication, physical therapy (unknown amount), chiropractic, aqua therapy 8 sessions, and right knee arthroscopy 7-3-06. Medical records dated 9-2-15 indicate that the injured worker complains of left hip pain and lumbar spine pain and radiation to the bilateral lower extremities (BLE). The pain is unchanged from previous visits and rated 4-8 out of 10 on the pain scale. The physician indicates the pain is moderate to severe. Per the treating physician report dated 9-2-15 the injured worker has not returned to work. The physical exam reveals tenderness of the bilateral trochanteric and gluteus, positive Faber test, lumbar spine tenderness and positive straight leg raise bilaterally. The physician recommended H-wave stimulator unit. There is no documentation in the medical records of prior trial of Transcutaneous electrical nerve stimulation (TENS) unit. The requested service included H-wave home stim unit. The original Utilization review dated 10-21-15 non-certified the request for H-wave home stim unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave home stim unit: 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: Submitted reports have not provided specific medication name or what decreasing dose has been made as a result of the H-wave unit trial. There is no change in ADL status or functional improvement demonstrated to support for this home unit. The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. It is not clear if the patient has underwent a one month H-wave use; however, there is no documented consistent pain relief in terms of decreasing medication dosing and clear specific objective functional improvement in ADLs have not been demonstrated. Per reports from the provider, the patient still exhibited persistent subjective pain complaints and impaired ADLs for this chronic injury. There is no documented failed trial of TENS unit, PT treatment, nor any indication the patient is participating in a home exercise program for adjunctive exercise towards a functional restoration approach. The patient's work status has remained unchanged, remaining off work. The H-wave home stim unit is not medically necessary and appropriate.