

Case Number:	CM15-0042367		
Date Assigned:	03/12/2015	Date of Injury:	01/27/2012
Decision Date:	04/22/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/06/2015

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 47 year old, male patient who sustained an industrial injury on 01/27/2012. A therapy visit dated 12/18/2014, reported the patient having gone through 5 physical therapy sessions. He is also seeing a massage therapist on his own, every two weeks, which allowed him to return to work. He is working under modified job duties and his basic care he is deemed as independent with difficulty. He rated his pain a 5 out of 10 in intensity, to the right low back with radiating pain into anterior left hip and stabbing pain into left lateral foot. He has numbness in the medial arch and first toe of left foot. He is found with left sided tenderness but able to tolerate increasing pressure along spin and spinal musculature. initiated lighth core stability exercises today. The plan of care involved continue with current rehabilitation program; advance as tolerated.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Purchase of Home H-Wave device: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

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

Decision rationale: Based on the 10/6/14 progress report provided by the treating physician, this patient presents with low back pain, radiating to his left lower extremity with left hip/foot pain, pain rated 3-5/10 on VAS scale. The treater has asked for PURCHASE OF HOME H-WAVE DEVICE but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient is s/p massage therapy, which has helped his pain significantly more than other treatments per 10/6/14 report. The patient is s/p physical therapy, which was moderately helpful, as well as medication. The patient has not had prior surgery for the back, but had right shoulder rotator cuff surgery in 2008. The patient is currently working with restrictions. The MTUS pg. 117, 118 - regarding , H-wave stimulation states the following: 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 (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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). The treater does not discuss this request in the single progress report provided. The utilization review letter dated 2/9/15 quotes a 1/23/15 progress report that describes a month-long trial of the H-wave unit from 10/23/14 to 11/14/15, which eliminated the need for oral medication and reported ability to perform more activity and greater overall function. The utilization review letter, however, denies request as the improvement level was not quantified. In this case, the treater does not provide documentation as to how often the unit was used, as well as outcomes in terms of pain relief and function. However, the UR letter references functional improvement along with medication reduction, which would not have been possible without significant, quantifiable pain reduction. The request IS medically necessary.