

Case Number:	CM15-0014274		
Date Assigned:	02/02/2015	Date of Injury:	03/31/2014
Decision Date:	03/25/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/26/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The injured worker is a 49 year old female patient, who sustained an industrial injury on 03/31/2014. A primary treating office visit dated 12/04/2014 reported complaint of pain. She exhibits impaired range of motion and impaired activities of daily living. The patient reported a decrease in the need for oral medications and an increase in activities, after using a home heat wave therapy unit. She is diagnosed with sacroiliac strain/sprain. A request was made during this visit for a home heat therapy unit. On 12/26/2014 Utilization Review non-certified the request, noting the CA MTUS Chronic Pain Heat wave therapy was cited. The injured worker submitted an application for independent medical review of services.

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/indefinite: Upheld

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

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

Decision rationale: According to MTUS guidelines, H wave stimulation is not recommended in isolation. It could be used in diabetic neuropathy and neuropathic pain and soft tissue pain after failure of conservative therapies. There is no controlled supporting its use in radicular pain and focal limb pain. There is no documentation that the request of H wave device is prescribed with other pain management strategies in this case. Furthermore, there is no clear evidence for the need of indefinite H wave therapy without periodic control of its efficacy. There is no documentation of patient tried and failed conservative therapies. There is no documentation of failure of first line therapy and conservative therapies including pain medications and physical therapy. Therefore Home H-Wave Device purchase/indefinite is not medically necessary.