

Case Number:	CM15-0117435		
Date Assigned:	06/25/2015	Date of Injury:	07/17/2014
Decision Date:	07/24/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/18/2015

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, Alabama, 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 39 year old male who sustained an industrial injury on July 17, 2014. He has reported lower back pain and has been diagnosed with chronic low back pain and degenerative disc disease of the lumbosacral spine at L4-L5 and L5-S1 with the minimal neuroforaminal narrowing. Treatment has consisted of modified work duty, medications, chiropractic care, and a TENS unit. Examination of the lumbar spine notes normal lordosis. On palpation there was tenderness in the lumbosacral spine and paraspinal muscle with minimal stiffness. The injured worker had poor posture. Range of motion of the lumbar spine was painful in all directions, but within normal limit. Straight raise in sitting and supine was negative. Fabere-Patrick, extension and Gaenslen tests were negative. The treatment request included a purchase of home H-wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Home H-wave device: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 and knee pain. There is no documentation that the request of H wave device is prescribed with other pain management strategies. Furthermore, there is no clear evidence for the need of indefinite H wave therapy without periodic control of its efficacy. Therefore, the request for purchase of Home H-Wave Device is not medically necessary.