

Case Number:	CM15-0179445		
Date Assigned:	09/21/2015	Date of Injury:	10/06/2005
Decision Date:	10/27/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/11/2015

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: Emergency 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 63 year old male, who sustained an industrial injury on October 6, 2005. The injured worker was being treated for lumbar disc degeneration. On April 15, 2015, the injured worker reports a back problem. He takes Flexeril 1-2 times per day, Ibuprofen 2-3 times per day, and Vicodin 3 times per week to control his pain. He reports that his H-Wave unit is "the one thing that really helps to control his back pain." He works 8 hours per week. The physical exam (April 15, 2015) did not include a documentation of a lumbar spine assessment. The provided medical records did not include diagnostic studies of the lumbar spine. Treatment has included an H-Wave unit and medications including pain, muscle relaxant, and non-steroidal anti-inflammatory. The requested treatments included an H-Wave equipment repair or replacement and three months supplies (thirty six electrodes and three bottles of Ultra Gel). On September 9, 2015, the original utilization review non-certified a request for H-Wave equipment repairs or replacement and three months supplies (thirty six electrodes and three bottles of Ultra Gel).

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave equipment repair or replacement: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: As per MTUS Chronic pain guidelines H-Wave stimulation (HWT) is not recommended as an isolated therapy. It may be recommended in cases of diabetic neuropathy and chronic soft tissue inflammation with a successful 1month trial if used as part of evidence based functional restoration program. Several criteria need to be met before HWT may be recommended. 1) Failure of conservative therapy Fails criteria. There is no documentation of what was attempted prior to HWT. 2) Failure of TENS therapy Fails criteria. There is no documentation of what was attempted prior to HWT. 3) Needs to be used as part of a functional restoration program, should not be used as an isolated treatment Fails criteria. There is no documentation of an actual functional restoration program or what the end goal of HWT is suppose to be. 4) Successful trial of HWT for 1month Fails criteria. Patient has been using HWT chronically for several years. Provider has not documented any objective improvement in pain or functional status. While patient claims that he needs it function, the lack of documentation fails to support objective improvement. Patient does not meet any criteria to even recommend a trial much less a request for permanent use of this device. Despite patient's chronic use of this device, guidelines do not support the use of HWT on this patient and therefore any repair or supplies requested are considered not medically necessary.

Three months supplies (thirty six electrodes and three bottles of Ultra Gel): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: As per MTUS Chronic pain guidelines H-Wave stimulation (HWT) is not recommended as an isolated therapy. It may be recommended in cases of diabetic neuropathy and chronic soft tissue inflammation with a successful 1month trial if used as part of evidence based functional restoration program. Several criteria need to be met before HWT may be recommended. 1) Failure of conservative therapy Fails criteria. There is no documentation of what was attempted prior to HWT. 2) Failure of TENS therapy Fails criteria. There is no documentation of what was attempted prior to HWT. 3) Needs to be used as part of a functional restoration program, should not be used as an isolated treatment Fails criteria. There is no documentation of an actual functional restoration program or what the end goal of HWT is suppose to be. 4) Successful trial of HWT for 1month Fails criteria. Patient has been using HWT chronically for several years. Provider has not documented any objective improvement in pain or functional status. While patient claims that he needs it function, the lack of documentation fails to support objective improvement. Patient does not meet any criteria to even recommend a trial much less a request for permanent use of this device. Despite patient's chronic use of this device, guidelines do not support the use of HWT on this patient and therefore any repair or supplies requested are considered not medically necessary.