

Case Number:	CM15-0061674		
Date Assigned:	04/07/2015	Date of Injury:	11/15/2013
Decision Date:	05/06/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	04/01/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 44 year old male, who sustained an industrial injury on 11/15/13. He reported initial complaints of back pain with radiation to the both lower extremities. The injured worker was diagnosed as having lumbar sprain, lumbar disc degeneration, chronic pain, lumbar facet arthropathy, lumbar radiculopathy, and lumbar spinal stenosis. Treatment to date has included medication, home H wave, transcutaneous electrical stimulation (TENS) unit, physical therapy. MRI results were performed on 2/11/14. Currently, the injured worker complains of intermittent back pain with radiation down the bilateral extremities. Per the orthopedic report dated 3/14/15, the exam noted tenderness to the lumbosacral spine. Straight leg raise is negative. Motor strength, sensory exam, deep tendon reflexes, toe and heel stance are within normal limits bilaterally. Current plan of care included pain management, home exercise program, and work modification. The requested treatments include Home H-wave device purchase.

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: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation.

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

Decision rationale: The California MTUS section on H-wave therapy states: 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 patient has a reported 40% reduction in pain and an increase in functional activity after using the H-wave device 2 times a day for 45 days. All criteria as outlined above have been met. With the objective measures of improvement in pain and function, the request is medically necessary.