MAXIMUS Federal Services

Case Number:	CM14-0152666		
Date Assigned:	09/22/2014	Date of Injury:	01/19/2013
Decision Date:	11/05/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/18/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 65-year-old female who reported an injury on 01/19/2013. The mechanism of injury was not provided. On 03/04/2014, the injured worker presented with pain radiating to the bilateral legs, and left knee pain. Upon examination of the cervical spine, there was pain with terminal range of motion and tenderness to palpation over the paraspinal musculature. There was decreased sensation to light touch at the bilateral L4, L5 and S1 dermatomes with a positive straight leg raise. The diagnoses were: lumbar spine sprain with degenerative disc disease, rule out lumbar radiculopathy; cervical thoracic spine strain, rule out cervical radiculopathy; rule out right wrist De Quervain's tenosynovitis and intersection syndrome; and complaints of depression, anxiety and sleep difficulty. Prior therapy included medications. The provider recommended a home H wave device purchase; the provider's rationale is not provided. The Request for Authorization form was not included in the medical documents for review.

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: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend the H wave unit as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic, neuropathic or chronic tough tissue inflammation if used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative treatment. The medical documentation does not address any numbness or muscle weakness to suggest neuropathic pain. Furthermore, there is a lack of documentation that the injured worker participates in a program of evidence based functional restoration to include physical therapy or home exercise program used as an adjunct with a home H wave device. There is a lack of documentation that the injured worker had a successful 1 month trial of a home H wave device to support a purchase of the unit. Additionally, the provider's request does not indicate the site at which the home H wave device was indicated for in the request as submitted. The request for a Home H-Wave Device Purchase is not medically necessary.