

<b>Case Number:</b>	CM13-0021769		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	01/09/2003
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	08/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2013

### 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 Emergency Medicine and is licensed to practice in California. 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:

Patient with reported date of injury on 1/9/2003. No mechanism of injury was provided. Patient has diagnosis of cervical neck pain, chronic low and mid back pain, bilateral lower extremity radicular pain, bilateral upper extremity radicular pain, lumbar disc disease, cervical disc disease, cervical and lumbar radiculopathy, R shoulder impingement syndrome, R wrist de Quervain tenosynovitis, and R hand arthritis. Patient has a prior history of multiple lumbar fusions and Cervical fusion at C4-C7. Pain management also gives him a diagnosis of opioid dependency and chronic pain syndrome. Medical records from primary treating physician and consultants reviewed. Last report available until 7/23/13. Patient has multiple pains including pain to entire spine, R hand, both arms and both legs from "radicular pain". Objective exam reveals pain along cervical spine, spasm and decreased range of motion(ROM), facet tenderness and "radiculopathy at C5-7". R shoulder exam reveals impingement sign, painful ROM, limited ROM. Lumbar spine exam shows healed scar, spasms, painful ROM. Lasegue positive bilaterally. Positive straight leg raise bilaterally. Motor strength is 4/5. Report from pain management on 9/30/13 reports urine drug screen that is positive for soma(which he is not suppose to be on) and methamphetamines. Pain management is tapering off his oxycontin. He is also documented to be on zantac, gabapentin and cymbalta. No advance imaging reports was provided. There are some notes that mentions prior MRIs but these were not provided. Unknown prior treatment. There is note about home exercise and walking program. No medication list was provided. Except noted above by Pain management. The H-wave was requested because "TENS/EMS was not strong enough." A physician addendum report date 9/16/13 notes that pt had H-wave trial already done. There is no note if this trial was approved by UR and the results of the trial does not change the UR decision on the original request from 7/23/13. Utilization review is for H-wave unit rental for 30days. Prior UR on 7/31/13 recommended denial.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**H-WAVE UNIT RENTAL X 30 DAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, H-Wave Stimulation.

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

**Decision rationale:** There is a note from 9/16/13 that a 1month H-wave trial was done. There is no note that if this was UR approved. The results of this trial do not change the current UR since prospective data does not change the review of the original UR request when it comes to medical necessity. As per MTUS Chronic pain guidelines, H-Wave Stimulation (HWT) is not recommended as an isolated intervention but may be recommended under certain criteria. The provided documentation fails to meet criteria. H- Wave Stimulation needs to be part of an Evidence Based functional restoration program. Patient does not meet criteria since there is no documentation of any such program or proper documentation of pain control or activity of daily living. There also needs to be a failure of TENS. There is no documentation of how long this has been tried, what it means by "not strong enough" and why TENS has failed since there is no pain scale noted. As per MTUS Guidelines, the provided documentation does not support the use of HWT. H-wave Stimulation is not medically necessary.