

<b>Case Number:</b>	CM13-0044951		
<b>Date Assigned:</b>	02/03/2014	<b>Date of Injury:</b>	03/26/2012
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 patient is a 45-year-old male who reported an injury on 03/26/2012 after he moved a large object. The patient reportedly sustained an injury to his cervical and lumbar spine. The patient's treatment history included medications, physical therapy, chiropractic care, a TENS unit, and acupuncture. The progress note dated 10/11/2013 provides a request for an H-Wave unit. However, it was noted that the patient was not physical examined during that visit. The patient's diagnoses included upper back sprain/strain, and lumbar spine sprain/strain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOME H-WAVE DEVICE ONE MONTH HOME USE EVALUATION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

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

**Decision rationale:** The requested HOME H-WAVE DEVICE ONE MONTH HOME USE EVALUATION is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends an H-Wave therapy device for a 1 month clinical trial for patients who have ongoing pain that has not responded to other types of chronic pain

management to include a TENS unit. The clinical documentation submitted for review does indicate that the patient has not responded to several treatment modalities to include physical therapy, chiropractic care, acupuncture, and a TENS unit. However, the patient's most recent clinical documentation does not provide an evaluation of the patient. Therefore, ongoing deficits that would benefit from an H-Wave therapy device cannot be determined. As such, the requested HOME H-WAVE DEVICE ONE MONTH HOME USE EVALUATION is not medically necessary or appropriate.