

<b>Case Number:</b>	CM13-0065029		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/21/2001
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 Anesthesiology, Pain Management and is licensed to practice in Florida. 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 56-year-old male who reported an injury on 05/21/2001. The mechanism of injury was not provided for review. The patient ultimately underwent cervical fusion followed by hardware removal. The patient recently underwent L3-4 discectomy and fusion in 07/2013. This was followed by postoperative physical therapy. The patient's most recent clinical evaluation documented that the patient was neurologically stable upon examination of both lower extremities. It was also noted that the patient has radiographic evidence of a well consolidating fusion at the L3-4 level. The patient's treatment plan included continuation of physical therapy and an H-Wave therapy treatment machine for home use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOME H WAVE STIMULATOR FOR THE LUMBAR SPINE S/P LUMBAR FUSION:**  
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 requested HOME H WAVE STIMULATOR FOR THE LUMBAR SPINE S/P LUMBAR FUSION is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends this treatment after the patient has failed to respond to initial conservative care to include physical therapy, medications, and a TENS unit. The clinical documentation submitted for review does provide evidence that the patient is participating in physical therapy and making progress. Additionally, the California Medical Treatment and Utilization Schedule recommend a 30-day trial of an H-Wave therapy unit for appropriately identified patients. The request as it is submitted does not clearly identify whether the request is for rental or purchase. As such, the requested HOME H WAVE STIMULATOR FOR THE LUMBAR SPINE S/P LUMBAR FUSION is not medically necessary or appropriate.