

<b>Case Number:</b>	CM14-0005412		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	11/02/2002
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 Physician 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 46 year old female who was injured on 11/02/2002. Mechanism of injury is unknown. Prior treatment history has included acupuncture and H-Wave unit. Medications include muscle relaxants and topical compounded cream as well as Voltaren-XR and cyclobenzaprine. PR-2 dated 10/21/2013 documented the patient continues to experience pain in the thoracic spine and lumbar spine. Pain is increased to activities and prolonged position. The patient performed a modified work duty. She denies numbness, tingling or radiating pain to the lower extremities. Objective findings on examination of the thoracic spine reveal tenderness and spasm. Rotation is 30 degrees bilaterally. Examination of the lumbar spine reveals the patient lacks 30 degrees from fingertips to floor. Extension is 10 degrees. Spasm is present over the paravertebral musculature bilaterally with tenderness. Straight leg raising test is negative in the seated and supine positions. Diagnoses: 1. Cervical spine musculoligamentous sprain 2. Thoracic spine musculoligamentous sprain 3. Lumbosacral musculoligamentous sprain Treatment Plan: 1. The patient to continue with medications including Voltaren-XR and cyclobenzaprine. 2. Acupuncture is recommended 2 times per week for 8 weeks. 3. Electrodes are needed for H wave unit. 4. Back support is needed. 5. The patient is to use heat and ice. UR report dated 12/11/2013 did not certify the request for Electrodes for H-Wave Unit because there is no clear evidence that the claimant has received any significant benefit from prior use of H-Wave unit in terms of pain relief and/or improved function. Therefore the electrodes are noncertified. The request for Back Support was not certified because lumbar supports are not recommended in the context of chronic pain as is present here.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ELECTRODES FOR H WAVE UNIT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, H-WAVES STIMULATION (HWT), 118

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

**Decision rationale:** According to the California MTUS guidelines, H-wave unit is "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 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)." In this case, there is documentation that the employee had exacerbation of the lumbar spine pain and has limited range of motion, tenderness and spasms on examination. The prior treatment includes medications, acupuncture, and H-wave unit; however, there is no documentation of trial and failure of TENS unit. Also, guidelines indicate that continued use of H-wave unit is recommended if there is documentation of adjunctive treatment modalities with active functional restoration and as to how often the unit was used, as well as outcomes in terms of pain relief and function. The records submitted for review fail to document if the prior treatment provided any therapeutic benefit or functional improvement. Therefore, the request for electrodes for H-wave unit is not medically necessary and is non-certified.

**BACK SUPPORT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES 2ND EDITION, CHAPTER 12, LOW BACK , 301

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute and Chronic), Lumbar supports

**Decision rationale:** According to the California MTUS/ACOEM guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. According to the ODG, lumbar support is "not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." In this case, this employee has chronic neck and back pain and the guidelines do not support its use for chronic pain. Thus, the medical necessity has not been established and the request is non-certified.

