

<b>Case Number:</b>	CM14-0017440		
<b>Date Assigned:</b>	04/14/2014	<b>Date of Injury:</b>	06/01/2009
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	01/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2014

### 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 and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 34-year-old female with date of injury of 06/01/2009. The listed diagnoses per [REDACTED] dated 11/27/2013 are post laminectomy syndrome, lumbar, SI syndrome and status post right SIJ injection on 11/15/2013. According to the report, the patient recently received a right SIJ injection and she reported 25% relief of her right lower extremity pain. The pain in her lower leg has improved, but she continues to report pain in the low back and right lateral thigh. She continues to use her H-wave unit which provides her with good relief. Examination shows the lumbar spine range of motion is diminished. There is moderate tenderness to palpation of the lumbar paraspinal muscles on the right. Reflex exam shows 2+/2 in the lower extremity bilaterally, no clonus noted. Straight leg raise test is negative. The provider is requesting an H-wave device purchase for the lower back.

### 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 FOR LOW BACK:** Upheld

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

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

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting an H-wave device purchase for the low back. The California MTUS Guidelines page 117 and 118 supports the 1-month home-based trial of an H-wave treatment as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidenced-based functional restoration and only following failure of initially recommended conservative care including recommended physical therapy (i.e. exercise) and medications, plus TENS. The records show that the patient is currently using the H-wave device at home and is reporting "good relief." In this case, while the patient reports good relief from H-wave use, the records do not show that the patient has tried and failed a TENS unit in the past. Furthermore, the patient continues to report significant pain in the succeeding reports while utilizing the H-wave device at home. No documentation of function or medication reduction is provided. Recommendation is for denial. Disclaimer: MAXIMUS.