

<b>Case Number:</b>	CM14-0169888		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	02/18/2003
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	10/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 & Rehabilitation, and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 63 year old male who sustained a work injury on 2-18-03. Office visit on 9-21-14 notes the claimant has pain rated 10/10. His pain is relieved by heat and medications. The claimant also noted numbness, tingling, spasms and headaches. The claimant has trigger points in the upper trapezius, lower trapezius, splenius capitis, quadratus lumborum, and thoracolumbar paraspinal muscles bilaterally. He also has pain with range of motion in the neck and lumbar spine, limited motor strength, paresthesia to light touch in the lateral left leg. The claimant is currently treated with medications. Note dated 9-19-14 notes the claimant had improved ADLs with H wave trial and reduce use of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 home H-wave unit:** 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 Page(s): 117-118.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that H wave stimulation 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. The claimant has had a 30 day trial noting increased ADL and decrease medications. However, there are no specifics noting what medications have decreased, decrease in quantity of prescribed medications, daily pain dairies noting objective functional improvement, what ADL's have increased. The improvement is nonspecific and not objective. As of 9-21-14 his medications still included Oxycodone, Zanaflex, Flector patches, Kadian, Lidoderm, Prilosec, Wellbutrin, and Trazadone. Further, there is an absence in documentation noting that this will be used in conjunction with a functional restoration program. Based on the Chronic Pain Medical Treatment Guidelines as well as ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.