

<b>Case Number:</b>	CM14-0027707		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/08/2001
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2014

### 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 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 injured worker is a 58-year-old male who reported an injury on 08/08/2001. The mechanism of injury was not provided. On 01/22/2014, the injured worker presented with low back pain and right lower extremity pain. Upon examination, there was good range of motion to the lower back and neck with slightly decreased range of motion on flexion and extension. He also had a slightly lordotic gait. Diagnoses were low back pain, lumbar radiculopathy, degenerative disc disease of the lumbar spine and lumbar stenosis. Prior therapy included surgery, medications and physical therapy. The provider recommended one home H wave device. The provider's rationale was not provided. The Request For Authorization was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One home H wave device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The request for a home H wave device is not medically necessary. The Chronic Pain Medical Treatment Guidelines do not recommend the H wave as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathic or chronic soft tissue inflammation. If used as an adjunct to the program of evidence based functional restoration, this should be used only following failure of initially recommended conservative care including recommended physical therapy, medications plus transcutaneous electrode nerve stimulation. In a recent retrospective study suggesting the effective of the H wave device, the injured worker's selection criteria including physician documented diagnosis of chronic tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications and TENS. The medical documentation lacks evidence of failure to respond to conservative treatment, as the H wave should not be used as an isolated intervention and there is no mention of physical therapy in conjunction with the H wave device or a home exercise program, the H wave device would not be warranted. Additionally, the provider's request does not indicate whether the H wave device would be rented or purchased in the request as submitted. There was no mention that the injured worker has undergone an adequate 30 day in home trial to determine the efficacy of the H wave therapy. As such, the request is not medically necessary..