

<b>Case Number:</b>	CM14-0034808		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/24/2006
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	02/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 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:

The injured worker is a 55 year old female whose date of injury is 03/24/2006. The mechanism of injury is described as cumulative trauma secondary to her work as an ironer. The injured worker is status post C4-5, C6-7 corpectomy in September 2012 as well as bilateral carpal tunnel release (right on 03/15/08 and left on 06/21/08). An MRI of the lumbar spine dated 05/01/13 revealed broad based posterior herniation at L5-S1, T12-L1 and L3-4, and broad based posterior and left foraminal herniation of L4-5 disc.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective (DOS: 2/17/14): H-Wave unit for purchase:** Upheld

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

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

**Decision rationale:** There is no comprehensive assessment of treatment completed prior to this date or the injured worker's response thereto submitted for review to establish that she had failed conservative treatment including physical therapy and transcutaneous electrical nerve stimulator (TENS) as required by the MTUS Chronic Pain Guidelines. There was no indication that the

injured worker had undergone a successful trial of H-wave to establish efficacy of treatment. There was no recent physical examination submitted for review and no specific, time-limited treatment goals were provided.

**Retrospective (DOS: 2/17/14): 3 Packets of electrodes:** Upheld

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

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Retrospective (DOS: 2/17/14): Conductive gel:** Upheld

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

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Retrospective (DOS: 2/17/14): H-Wave unit for 3 month rental:** Upheld

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

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

**Decision rationale:** There is no comprehensive assessment of treatment completed prior to this date or the injured worker's response thereto submitted for review to establish that she had failed conservative treatment including physical therapy and transcutaneous electrical nerve stimulator (TENS) as required by the MTUS Chronic Pain Guidelines. There was no recent physical examination submitted for review and no specific, time-limited treatment goals were provided. As such, the request is not medically necessary and appropriate.