

<b>Case Number:</b>	CM14-0065054		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	08/01/2007
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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 48-year-old male, who reported an injury on 08/01/2010. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar degenerative disc disease with radiculopathy. The previous treatments included medication and H wave unit. Within the clinical note dated 02/14/2014, it was reported the injured worker complained of back pain with radicular symptoms. He complained of leg pain with moderate limitations with sitting and moderate to severe limitations with sleeping, walking, and exercise. There was no physical examination within the clinical documents submitted. Within the previous note dated 01/21/2014, the provider noted upon the physical examination the injured worker had pain to palpation at L4-5 and L5-S1. Lateral bending left and right, flexion and extension at 25% decrease. The provider requested an H wave unit. However, a rationale is not provided for clinical review. The Request for Authorization was submitted on date of 12/23/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave Device and System for the Lumbar Spine E1399:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-127.

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

**Decision rationale:** The request for Home H-Wave Device and System for the Lumbar Spine E1399 is not medically necessary. The California MTUS 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 a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medication, plus transcutaneous electrical nerve stimulation. In a recent retrospective study suggesting the effectiveness of the H wave device, the patient's election criteria included physician documented diagnoses of chronic soft tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conservative therapy. There is lack of documentation indicating the injured worker had tried and failed on conservative therapy. Furthermore, the guidelines would support purchase versus extension of rental period after the 1 month trial. The request submitted failed to provide whether the provider indicated the injured worker to purchase or rent the equipment. Therefore, the request is not medically necessary.