MAXIMUS Federal Services

| Case Number: | CM14-0153815 | | |
|---|---|---|---|
| Date Assigned: | 09/23/2014 | Date of Injury: | 06/26/1997 |
| Decision Date: | 08/17/2015 | UR Denial Date: | 09/08/2014 |
| Priority: | Standard | Application Received: | 09/19/2014 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old female sustained an industrial injury on 6/27/97. She subsequently reported back, knee and shoulder pain. Diagnoses include lumbar radiculopathy. Treatments to date include MRI testing, knee surgery (both knees), injections and prescription pain medications. The injured worker continues to experience back pain. Upon examination, tenderness to palpation is noted in the lumbar spine bilaterally. Straight leg raising is positive bilaterally. The right shoulder reveals tenderness in the subdeltoid bursa, Hawkin's and Speeds tests were positive. Range of motion was restricted in the left knee. The left knee reveals mild effusion in the knee joint. A request for H-wave 30 day rental was made by the treating physician.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**H-wave 30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

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

**Decision rationale:** As per MTUS Chronic pain guidelines H-Wave stimulation (HWT) is not recommended as an isolated therapy. It may be recommended in cases of diabetic neuropathy and chronic soft tissue inflammation with a successful 1month trial if used as part of an evidence based functional restoration program. Several criteria needs to be met before HWT may be recommended. 1) Failure of conservative therapy. Meets criteria. 2) Failure of TENS therapy. Fails criteria. There is no documentation of TENS trial. 3) Needs to be used as part of a functional restoration program, should not be used as an isolated treatment. Fails criteria. There is no documentation of an actual functional restoration program or what the end goal of HWT is suppose to be. 4) Successful trial of HWT for 1 month: Fails criteria. Since documentation does not properly document that HWT is part of an evidence based functional restoration program and no valid HWT trial was done, H-wave unit is not medically necessary.