

<b>Case Number:</b>	CM15-0167643		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	07/01/2012
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: Physical Medicine & Rehabilitation

### 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 39 year old female, who sustained an industrial injury on 07-01-2012. The injured worker is currently working full duty per 08-12-2015. Current diagnoses include cervical spondylosis without myelopathy and right upper extremity radiculopathy. Treatment and diagnostics to date has included physical therapy, occupational therapy, home exercise program, and medications. Current medications include Alavert D and nasal spray. Cervical spine MRI dated 02-23-2015 revealed small posterior annular bulges at C4-5 and C5-6 indenting the ventral subarachnoid space without cord or nerve root impingement. In a progress note dated 07-06-2015, the injured worker reported significant improvement of her symptoms with physical therapy. Objective findings included full strength and sensation in bilateral upper and lower extremities, continued neck range of motion improvement, and mild right trapezius tenderness noted without spasm. The Utilization Review with a decision date of 08-25-2015 non-certified the request for H-wave unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-wave unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Submitted reports have not provided specific medication name or what decreasing dose has been made as a result of the H-wave unit trial, if any. There is no change in ADL status or functional improvement demonstrated to support for this unit. The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. It is not clear if the patient has underwent a one month H-wave use; however, is without documented pain relief in terms of decreasing medication dosing and clear specific objective functional improvement in ADLs have not been demonstrated. Per reports from the provider, the patient still exhibited persistent subjective pain complaints without defined neurological deficits. There is no documented failed trial of TENS unit, PT treatment, nor any indication the patient is participating in a home exercise program for adjunctive exercise towards a functional restoration approach. The H-wave unit is not medically necessary or appropriate.