

<b>Case Number:</b>	CM15-0179457		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	10/18/2004
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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: Texas, California

Certification(s)/Specialty: Family Practice

### 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 71 year old female, who sustained an industrial injury on 10-18- 04. Medical records indicate that the injured worker is undergoing treatment for chronic low back pain, bilateral lumbar radiculitis, lumbar multilevel degenerative disc disease, moderate to severe lumbar spinal stenosis, neck pain, cervical degenerative disc disease, cervical spine stenosis, headaches, carpal tunnel syndrome, chronic pain syndrome and myofascial pain. The injured worker was noted to be permanent and stationary. On (8-20-15) the injured worker complained of neck pain with radiation to the arms, headaches, right hip pain and low back pain, which radiated to the right leg. The pain was rated 2-4 with medications and 8 out of 10 without medications. The pain was aggravated with extended activities and alleviated by medications, injections and physical therapy. Objective findings include tenderness in the right greater trochanter region. There was tightness in the right buttock and right lower lumbar paraspinal muscles. Treatment and evaluation to date has included medications, electrodiagnostic studies of the lower extremities, cervical and lumbar epidural steroid injections and physical therapy. The cervical epidural steroid injections on 5/26/15 improved the pain by 50-60% and the lumbar epidural steroid injections on 12/9/13 improved the pain by about 60%.Strength was normal in all extremities. Gait was normal. Current medications include Topamax, Omeprazole, Celebrex, Rizatriptan, Norco, Flexeril, Restoril and Lidoderm patches. The request for authorization dated 8-21-15 included a request for an H-Wave Unit (1-month rental). The Utilization Review documentation dated 8-28-15 non-certified the request for an H-Wave Unit (1-month rental).The patient had received an unspecified number of PT visits for this injury. The patient has had EMG

of bilateral lower extremity on 10/3/13 that revealed bilateral lower extremities radiculopathy. The patient's surgical history includes right knee surgery, right hip bursectomy and sinus surgeries. The patient has had history of HTN and heart disease. A recent detailed clinical examination of the gastrointestinal tract was not specified in the records provided. On review of system, patient does not have any complaints of gastrointestinal tract.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**H-wave unit one-month rental:** 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:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines H-wave stimulation (HWT) is "Not recommended as an isolated intervention, but a one-month home-based trial of H Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain, 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS)." Per the records provided, indications listed above were not specified in the records provided. Evidence of a trial and failure of a TENS for this injury was not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. Evidence of diminished effectiveness of medications or intolerance to oral medications was not specified in the records provided. The H-wave unit one-month rental is not medically necessary for this patient.