

<b>Case Number:</b>	CM15-0070020		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	10/14/1998
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### 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: New York, West Virginia, Pennsylvania  
 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:

The injured worker is a 55-year-old female who sustained an industrial injury on 10/14/98. She has reported initial complaints of burning pain in the low back and down her leg after bending down to pick up papers from the floor. The diagnoses have included lumbar degeneration, lumbosacral intervertebral disc disease, post laminectomy syndrome, chronic pain syndrome, anxiety /depression, and thoracic or lumbosacral neuritis or radiculitis. Treatment to date has included medications, diagnostics, Transcutaneous electrical nerve stimulation (TENS), physical therapy, conservative measures, and activity modifications. The diagnostic testing that was performed included X-rays of the lumbar spine and Magnetic Resonance Imaging (MRI) of the lumbar spine. The current medications included Norco, Clonazepam, Mirtazapine, Amitriptyline, and Sertraline. Currently, as per the physician progress note dated 1/13/15, the injured worker complains of aching in the elbows, wrists, knees and low back pain with tingling and numbness in the right lower leg and foot. The pain is alleviated with rest and medications. The pain was rated 10/10 without medications and 8/10 with medications. It was noted that she stated physical therapy but had increased pain so took a break. Physical exam of the lumbar spine revealed decreased sensation in the left leg, tenderness, increased pain with range of motion and positive straight leg raise on the left. The physician noted that she continues to have low back pain status post low back surgery. She was encouraged to continue home exercise program (HEP), heat, and ice. It was also noted that she has tried transcutaneous electrical nerve stimulation (TENS) in the past with increased pain noted. The physician requested treatments included Durable medical equipment (DME) home H-wave unit, purchase, Durable medical

equipment (DME) electrodes, 4-month supply and Durable medical equipment (DME) conductive gel, 4-month supply.

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

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

**Durable medical equipment (DME) home H-wave unit, purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** Guidelines do not support home H wave unit as an isolated intervention as evidence indicates effectiveness in conjunction with other treatments. Guidelines recommend monitoring decrease in analgesic requirements, functional benefits, duration of use and the number of times per day it was used. In this case, these criteria were not met and there was documented failure of a TENS unit. The request for an IF unit purchase is not medically appropriate and necessary.

**Durable medical equipment (DME) electrodes, 4 month supply:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** Electrodes are needed for use of home H wave units. In this case, the home H wave unit is not medically needed and appropriate. The request for electrodes is not medically appropriate and necessary.

**Durable medical equipment (DME) conductive gel, 4 month supply:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** Conductive gel is needed for use of home H wave units. In this case, the home H wave unit is not medically needed and appropriate. The request for conductive gel is not medically appropriate and necessary.