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| <b>Case Number:</b>   | CM15-0096196 |                              |            |
| <b>Date Assigned:</b> | 05/26/2015   | <b>Date of Injury:</b>       | 06/02/2009 |
| <b>Decision Date:</b> | 06/25/2015   | <b>UR Denial Date:</b>       | 05/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/19/2015 |

### 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: Preventive Medicine, Occupational 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 47 year old female who sustained an industrial injury on 5/14/15. The mechanism of injury is unclear. She currently complains of neck, low back and shoulder pain. Physical exam of the cervical spine shows evidence of muscle spasms and pain with movement; the lumbar spine exhibits muscle spasms, pain with movement, restricted motion and difficulty walking. Her pain level is 7/10. Medications include Prilosec, Soma, Norco, Orudis. Diagnoses include multilevel spondylosis; bilateral shoulder pain; bilateral knee pain; right foot crush injury; low back pain with right radiculopathy; decreased disc space C4-7. Treatments to date include medication, physical therapy. In the progress note dated 4/28/15 the treating provider's plan of care includes home H-wave device for purchase as the injured worker has not improved sufficiently with conservative care. If trial of this device is effective the provider requests continued and ongoing home use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave Device Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave stimulation (HWT).

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

**Decision rationale:** The MTUS Guidelines do not recommend the use of H-wave stimulation as an isolated intervention. A one-month home-based trial of H-wave stimulation may be considered as a noninvasive conservative option for 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 physical therapy and medications, plus transcutaneous electrical nerve stimulation. The injured worker used a Home H-Wave device on a trial basis from March to April 2015 with subjective increase in function and a 70% reduction in pain. However, the injured worker remains on chronic medications at the pre H-Wave dose and her work status has not changed. The request for Home H-Wave device purchase is not medically necessary.