

<b>Case Number:</b>	CM14-0140093		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	04/09/2013
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 records, presented for review, indicate that this 27-year-old male was reportedly injured on 4/9/2013. The mechanism of injury was noted as a fall. The most recent progress note, dated 7/1/2014, indicated that there were ongoing complaints of low back and right leg pains. The physical examination revealed the patient had a slightly antalgic gait. Lumbar spine muscle strength was 5/5, diminished sensation in all areas of the right leg. Positive tenderness to palpation was over the paraspinals. Limited range of motion was due to pain. Straight leg raise was positive on the right. No recent diagnostic studies are available for review. Previous treatment included physical therapy, acupuncture, injections, and medications. A request had been made for home H-wave device (purchase) and was not certified in the pre-authorization process on 8/7/2014.

### 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 Transcutaneous Electrotherapy H-Wave Stimulation (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 118 of 127.

**Decision rationale:** MTUS guidelines will support a one-month HWT (H-Wave Stimulation) for diabetic neuropathic pain and chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following a failure of conservative treatment, physical therapy, medications and transcutaneous electrical nerve stimulation (TENS). Review of the available medical records fails to document the criteria required for a one-month trial of H-Wave Stimulation. As such, this request is not considered medically necessary.