

<b>Case Number:</b>	CM13-0071562		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	10/25/2011
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 49-year-old female, who sustained an industrial injury on 10/25/11. On 12/27/13, the injured worker submitted an application for IMR for review of Home H-Wave Device. The treating provider has reported the injured worker complained of low back pain radiating down the and right leg pain. There was objective findings of the diagnoses have included low back pain, sciatica, insomnia, anxiety disorder and depression. Treatment to date has included MRI lumbar spine (9/10/13), EMG/NCV (9/9/13), injections, and medications. The medications listed are gabapentin and Tramadol. There were objective findings of positive straight leg raising test, tenderness of the lumbar paraspinal muscles and decreased sensation over the right L5 and S1 dermatomes. On 12/10/13 Utilization Review non-certified Home H-Wave Device. The MTUS Guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave Device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy (TENS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low and Upper Back Electrical stimulation devices.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that trans-cutaneous electrical stimulation devices can be utilized in the management of musculoskeletal pain. The utilization of electrical stimulation devices can lead to reduction in pain, increase in range of motion and functional restoration. The guidelines recommend a 30 days supervised trial treatment to demonstrate efficacy before the purchase of a home stimulatory unit. The records did not show documentation of successful trial period of the use of the Home-wave device. There are documentation of significant psychosomatic disorders that are associated with decreased efficacy and compliance with PT and stimulation treatment devices. The criteria for the use of Home H-wave device was not met.