

<b>Case Number:</b>	CM13-0024833		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	01/30/2013
<b>Decision Date:</b>	01/17/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 39-year-old male who reported an injury on 01/30/2013. Notes indicate that the patient sustained injuries as the result of a motor vehicle accident to the right knee, right shoulder, and back. At the time of injury, the patient was transported by ambulance to an emergency room and was discharged on the same day. Subsequently, the patient had undergone treatment with physical therapy and a lumbar epidural steroid injection. Qualified Medical Evaluation on 07/09/2013 indicated that the patient had been seen by a number of specialists and had an MRI completed with bilateral epidural steroids undertaken for the lower spine. Notes indicate that the patient also underwent formal physical therapy and is presently working normal duties. Current medication is indicated as tramadol 50 mg. Notes indicate that the patient was currently assessed with pain to the left shoulder, right knee, and lumbar spine, as well as secondary depression and insomnia and right 5th finger numbness. The current request for consideration is for a home H-wave device.

### 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 ACOEM. Decision based on Non-MTUS Citation ODG

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

**Decision rationale:** CA MTUS states that H-wave stimulation is not recommended as an isolated intervention, but that a 1 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). A request for authorization submitted 08/15/2013 details the request for a home H-wave device for 1 month rental directed to the diagnoses of status post ACL repair and lumbar radiculopathy. However, there is no currently supported guideline indicating necessity for an H-wave unit for rehabilitative treatment. Currently, the patient's right knee and right shoulder, as well as back, are being evaluated and treated orthopedically. Furthermore, there is a lack of documentation indicating that the patient has failure of initially recommended conservative treatment or medications or with transcutaneous electric nerve stimulation unit. Given the above, the request for home H-Wave device is not medically necessary and appropriate.