

<b>Case Number:</b>	CM13-0043475		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/10/2011
<b>Decision Date:</b>	08/01/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 36-year-old with a reported date of injury on October 10, 2011. The mechanism of injury was reported as a fall. The injured worker presented with pain in the left elbow with numbness and tingling in the left small finger. Upon physical examination, the left upper extremity presented with sensation to light touch. The hand and elbow range of motion was nearly full. The injured worker was status post left cubital tunnel surgery with ulnar nerve transposition on February 7, 2011. In addition, the injured worker was status post left cubital tunnel revision with scar revision on September 9, 2013. The clinical documentation provided for review indicates the injured worker previously participated in physical therapy, the results of which were not provided within the documentation available for review. The injured worker's diagnoses included status post arthroscopic surgery, status post left cubital tunnel surgery with ulnar nerve transposition, left forearm intersection syndrome, right medial epicondylitis and cubital tunnel syndrome, left scaphoid fracture status post fall at work, and left lateral epicondylitis. The injured worker's medication regimen was not provided within the documentation available for review. The Request for Authorization for home H-wave device was submitted on October 23, 2013. The rationale for the request was not provided within the documentation available for review.

### 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 H-Wave Stimulation (HWT).

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave stimulation may be considered as a non-invasive 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 following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. The clinical documentation provided for review dated October 29, 2013, indicated that the injured worker had 1 more physical therapy visit left. The medication regimen was not provided within the documentation available for review. The guidelines state that H-wave stimulation is not recommended as an isolated intervention. In addition, H-wave stimulation is to be used in adjunct to a program of evidence based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. There is a lack of documentation related to the therapeutic and functional benefit or failure of initial conservative care, including physical therapy. There is a lack of documentation related to the injured worker's medications or previous use of transcutaneous electrical nerve stimulation. In addition, the request as submitted fails to provide the specific site at which the H-wave device was to be used. The request also fails to determine whether the H-wave home device is for purchase or rental. Therefore, the request for a home H-wave device is not medically necessary or appropriate.