

<b>Case Number:</b>	CM13-0056280		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/06/2013
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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 Anesthesiology, has a subspecialty in Pain Medicine 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 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 patient is a 58-year-old male with 09/06/13 date of injury. He developed upper back pain while he was reaching above his head while rodding wires. The patient presented with pain levels 7-8/10 with bilateral trapezius muscles palpable tender points. The examination report dated 10/22/13 reveals moderate to severe cervical spine tenderness, painful range of motion lateral bending at 20% rotation at 50%. There is shoulder tender at AC joint, impedance, crepitus. Diagnoses include cervical sprain/strain, shoulder rule out internal derangement, anxiety and depression insomnia. Prior diagnosis include thoracic sprain. Request is for H-wave device-purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-WAVE DEVICE - PURCHASE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT) Page(s): 117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA MTUS 2009: 9792.24.2 Page(s): 117-118.

**Decision rationale:** Guidelines state that a one-month home-based trial of H-wave stimulation may be indicated with chronic soft tissue inflammation and when H-wave therapy will be used as

an adjunct to a method of functional restoration, and only following failure of initial conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). The guideline criteria are not met. There is no documentation of a TENS trial or outcomes. The purchase of the unit is not medically necessary as there is no documented evidence that a one-month trial has been carried out, nor that it has been successful. Recommendation is for not medically necessary.