

<b>Case Number:</b>	CM13-0068485		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/06/2013
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Orthopedic Surgeon, and is licensed to practice in Texas. 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 53-year-old male who reported an injury on 06/06/2013. The mechanism of injury was not specifically stated. The patient is currently diagnosed with distal radius fracture and peripheral edema. A primary treating physician's progress report was submitted by [REDACTED] on 10/24/2013. The patient reported persistent pain with activity limitation. Physical examination was not provided on that date. Treatment recommendations included a 3 month trial with an H-wave home care system. It is noted that the patient reported 60% improvement in symptoms following the use of an H-wave device. It was previously documented on 09/09/2013 by [REDACTED], the patient has been treated with conservative care including medication, physical therapy, and TENS therapy without relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-WAVE UNIT FOR THE RIGHT WRIST TIMES THREE MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a one month home based trial may be considered as a noninvasive conservative option. As per the documentation submitted, the patient has been previously treated with physical therapy, medications, and TENS therapy. However, the patient has also previously utilized an H-wave stimulation device. Although the patient reported 60% relief in symptoms, there is no evidence of how often the unit was used as well as outcomes in terms of pain relief and function. There was also no documentation of a physical examination on the requesting date of 10/24/2013. Therefore, there is no evidence of a functional deficit. Based on the clinical information received, the request is non-certified.