

<b>Case Number:</b>	CM14-0018707		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	02/28/2012
<b>Decision Date:</b>	07/09/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 & Rehabilitation 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 injured worker is a 53-year-old male who reported an injury on 02/28/2012. The mechanism of injury was not stated. Current diagnoses include neck pain, bilateral upper extremity repetitive injury, bilateral shoulder tendonitis, bilateral shoulder impingement, bilateral wrist tendonitis, bilateral DeQuervain's, bilateral medial epicondylitis, bilateral carpal tunnel syndrome and bilateral cubital tunnel syndrome. The injured worker was evaluated on 01/14/2014. The injured worker reported persistent pain in the bilateral upper extremities. Physical examination revealed tenderness to palpation of the bilateral wrists, bilateral medial epicondyles and bilateral shoulders. The injured worker also demonstrated restricted range of motion of the bilateral upper extremities, positive impingement testing and 5/5 motor strength. Treatment recommendations at that time included the continuation of current medications. A Request for Authorization was then submitted on 01/24/2014 for an H-wave homecare system for 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOME H-WAVE DEVICE, ADDITIONAL 3 MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** The California MTUS Guidelines state that H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. H-wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following the failure of initially recommended conservative care. As per the documentation submitted, there was no evidence of a failure to respond to physical therapy, medications and TENS therapy. There was no evidence of a successful 1 month trial with the H-wave stimulation unit prior to the request for an additional 3 month rental. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.