

<b>Case Number:</b>	CM14-0019685		
<b>Date Assigned:</b>	04/28/2014	<b>Date of Injury:</b>	02/02/2013
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2014

### 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 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 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 51 year old male who reported an injury on 02/02/2013 secondary to setting up a tent. An MRI of the right shoulder on 03/16/2013 revealed a partial-thickness tear of the distal supraspinatous tendon. The injured worker was previously treated with an unknown duration of physical therapy and 2 right shoulder subacromial injections prior to 07/18/2013 according to a comprehensive clinical note. Subsequently, he attended at least 6 additional sessions of physical therapy as of the clinical note dated 11/15/2013 and completed a home-exercise program. The injured worker was evaluated on 01/09/2014 and was noted to have tenderness to palpation over the subacromial region and acromioclavicular joint of the right shoulder. He was also noted to have a positive impingement test as well as 170 degrees of flexion and 150 degrees of abduction. Medications were note to include Voltaren gel. The injured worker was treated with a trial of an H-wave device and reported pain reduction from 7/10 to 5/10 with subjective improvements in range of motion and functional ability on 01/17/2014. A request for authorization was submitted on 01/23/2014 for a home H-wave device for 3 months. The documentation submitted for review failed to provide a request for authorization form.

### IMR ISSUES, DECISIONS AND RATIONALES

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

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

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT).

**Decision rationale:** California MTUS Guidelines do not recommend H-wave stimulation as an isolated intervention but as an adjunct to a functional restoration program for the treatment of chronic soft tissue inflammation. Although the injured worker attended 6 sessions of physical therapy as of 11/15/2013, there is no recent documentation of ongoing physical therapy. Furthermore, while the injured worker reported mild pain relief (7/10 to 5/10) and subjective functional improvement, there is a lack of objective functional improvement documented to warrant continued use of this device. Additionally, the guidelines recommend ongoing assessment of pain relief and function. The request as written is for three months of treatment with the H-wave device. Guidelines would recommend purchase of a device after the initial one month trial versus continuation of rental. As such, the request for a home H-wave device for 3 months is not medically necessary and appropriate.