

<b>Case Number:</b>	CM14-0157723		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	09/10/2008
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Family Medicine and is licensed to practice in North Carolina. 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 34-year-old with a reported date of injury of 09/10/2008. The patient has the diagnoses of adhesive capsulitis. On 06/16/2014, the patient was prescribed an H-wave device due to failure of the TENS unit to provide adequate relief or any objective benefits. Per the progress notes provided by the primary treating physician dated 08/26/2014, the patient noted improvement in pain with the use of the H-wave device as evidenced by the elimination of oral pain medication as well as improved function. There was no physical exam noted. The treatment plan recommendations included continued use of the H-wave device.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-wave device and supplies (rental or purchase):** 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 Page(s): 117.

**Decision rationale:** The California chronic pain medical treatment guidelines section on H-wave stimulation therapy states: H-wave stimulation (HWT) Not recommended as an isolated intervention, but a one-month home-based trial of H Wave stimulation may be considered as a

noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US. The patient has a diagnosis of chronic soft tissue inflammation. The patient has been given a trial of H-wave therapy with success. However the criterion for the use of HWT also includes evidence that it is being used as an adjunct to a program of evidence-based functional restoration. The documentation fails to meet these criteria and indicates the HWT is being used as a stand-alone therapy. Therefore the criteria as set forth above have not been met and the request is not medically necessary.