

<b>Case Number:</b>	CM14-0031857		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	04/24/2013
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 30-year-old female who reported an injury after she fell on 04/24/2013. The clinical note dated 06/16/2014 is typed but largely illegible. The diagnoses indicated right shoulder status post arthroscopic labral debridement, subacromial decompression, and open subpectoralis biceps tendinosis, probable selective posterior capsular tightness, right carpal tunnel syndrome, right knee status post contusion with mild arthrosis and possible chondral versus osteochondral injury. The injured worker reported ongoing right knee pain and ongoing right shoulder pain. On physical examination of the patient's right shoulder, the injured worker's range of motion was internal rotation 45 degrees on the left and 32 degrees on the right. The injured worker had 5/5 strength with supraspinatus external rotation. The injured worker completed physical therapy. The injured worker requested more physical therapy for her right shoulder. Prior treatments include diagnostic imaging and physical therapy. The injured worker's medication regimen included Naprosyn and Tylenol No. 3. The provider submitted a request for home H-wave device. A request for authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Pain (updated 01/07/14, H-wave stimulation (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT Page(s): 117.

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines state H-Wave is 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 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). There is no evidence in the documentation provided of the injured worker failing physical therapy. In addition, the request did not indicate if this was a rental or a purchase. Furthermore, the provider did not indicate a rationale for the request. Additionally, the provider did not clearly specify a body part. Therefore, the request for Home H-Wave device is not medically necessary and appropriate.