

<b>Case Number:</b>	CM14-0034352		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	07/28/2013
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	03/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 39-year-old female who reported an injury on 04/03/2009. The mechanism of injury was a fall. The diagnoses included right distal radius fracture status post ORIF. Previous treatments included an EMG, x-ray, surgery, physical therapy, medication, and occupational therapy. Within the clinical note dated 02/06/2014, it was reported the provider requested a 30-day evaluation trial of an H-Wave home system for the reduction or elimination of pain. The provider's request is also for improvement of functional ability and activities of daily living. The Request for Authorization was not provided for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave unit x 1 month for the Left Distal Radius:** 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) Page(s): 117.

**Decision rationale:** The request for a home H-Wave unit x1 month for the left distal radius is not medically necessary. The California MTUS Guidelines do not recommend the H-Wave as an isolated intervention, but 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 and medications, plus transcutaneous electrical nerve stimulation. In recent retrospective study suggesting effectiveness of an 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 of the spine that was unresponsive to conservative therapy. There is a lack of clinical documentation indicating the injured worker had any numbness or muscle weakness to suggest neuropathic pain. There is a lack of significant subjective and objective clinical documentation. The provider failed to document an adequate and complete physical examination. The request submitted failed to provide whether the H-Wave would be for rental or purchase. The medical necessity for the H-Wave has not been documented. Therefore, the request is not medically necessary.