

<b>Case Number:</b>	CM14-0044691		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	08/13/2013
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 60-year-old male who reported an injury on 08/13/2013. The mechanism of injury was not provided. On 02/26/2014, the injured worker presented with pain in the left elbow with numbness. Upon examination of the left shoulder, there was range of motion value of 160 degrees of active assisted forward flexion and 45 degrees of external rotation. There was 5/5 strength with external rotation and 4+/5 over the supraspinatus. The diagnoses were left shoulder status post arthroscopic labral debridement, chondroplasties, biceps tenotomy, subacromial decompression, rotator cuff repair, and attempted open subpectoralis biceps tenodesis. Previous treatment included surgery, physical therapy, and medications. The provider recommended an additional rental of a home H-wave device x3 months. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional rental of home H-wave device x 3 months:** 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 (HWT) Page(s): 117.

**Decision rationale:** The California MTUS Guidelines do not recommend the H-wave device is an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathic or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration. It is only recommended following failure of initially recommended conservative care, including recommended physical therapy and medications and transcutaneous electrical nerve stimulation (TENS). There is lack of measurable baseline as to which to measure the efficacy of the prior H-wave therapy. Additionally, an H-wave device must be used as an adjunct to a program of evidence based functional restoration such as physical medicine or home exercise. Furthermore, the guidelines would support purchase versus extension of rental period after the one month trial period. The provider's request does not indicate the site that the H-wave device was intended for in the request as submitted. As such, Additional rental of home H-wave device x 3 months is not medically necessary.