

<b>Case Number:</b>	CM14-0049135		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	03/21/2013
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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, has a subspecialty in Pain Management 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:

This is a female patient with the date of injury of March 21, 2013. A Progress Report dated February 25, 2014 identifies Subjective Complaints of pain and impaired Activities of Daily Living. Objective Findings identify impaired range of motion. Diagnoses identify depression secondary to ongoing pain, carpal tunnel syndrome, internal derangement right hip and right knee, lumbar intervertebral disc syndrome, radiculopathy lumbar, bicipital tendon tendinosis, and impingement syndrome right shoulder. Treatment Plan identifies H-wave. PT, medications, and TENS have already been tried.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H Wave Device Neck, Right Ankle, Right Knee, Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 117-118.

**Decision rationale:** Regarding the request for a Home H Wave Device Neck, Right Ankle, Right Knee, Right Shoulder, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the

treatment of pain. Guidelines go on to state that H-wave stimulation 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation available for review, there are boxes checked indicating that the patient has undergone physical therapy and a clinical tens unit trial. However, diabetic neuropathic pain or chronic soft tissue inflammation is not identified. There is no indication as to how much physical therapy the patient has undergone, and what the specific response to that therapy might have been. Additionally, it is unclear whether the patient underwent a 30 day tens unit trial as recommended by guidelines. There is no statement indicating how frequently the tens unit was used, and what the outcome of that tens unit trial was for this specific patient. In the absence of such documentation, the currently requested Home H Wave Device Neck, Right Ankle, Right Knee, Right Shoulder is not medically necessary.