

<b>Case Number:</b>	CM14-0061772		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	05/29/2010
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2014

### 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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 54-year-old female who reported an injury on 05/29/2010. The mechanism of injury was noted to be a fall. Prior treatments included physical therapy, medications, and transcutaneous electric nerve stimulation. The injured worker's diagnosis was noted to be cervical strain and right wrist strain. Provided within the documentation for review was one Primary Treating Physician's Progress Report addendum. In the subjective complaints, it was noted that the injured worker complained of pain, exhibited impaired range of motion, and exhibited impaired activities of daily living. The objective findings were not noted. Treatment goals included an H-wave device, TENS unit, physical therapy and exercise. The provider's rationale for the requested H-wave unit was provided within the documentation. A request for authorization for medical treatment was provided and dated 03/31/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-Wave unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Page(s): 117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation (HWT) Page(s): 117-118.

**Decision rationale:** The California MTUS Guidelines Chronic Pain Medical Treatment Guidelines do not recommend H-wave stimulation as an isolated intervention, but a 1 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 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. The documentation provided for review fails to provide enough documentation to warrant H-wave stimulation. The documentation fails to note diabetic neuropathic pain or chronic soft tissue inflammation. There is no documentation to support an evidenced based functional restoration program. There is no evidence within the documentation to indicate failed conservative care. Therefore, the request for H-wave unit is not medically necessary.