

<b>Case Number:</b>	CM14-0093108		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	12/16/2009
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	06/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 71 y/o female who sustained an industrial injury on 12/16/2009. The mechanism of injury was not documented in the clinical records submitted with this request. Her diagnoses include right arm pain, right shoulder pain, right elbow pain, right wrist pain and chronic pain syndrome. She continues to complain of right arm pain and on physical exam shoulder abduction was to 90 degrees and was pain limited. There was minimal internal rotation and forward flexion due to pain. Strength was 4/5 in the right upper extremity. There was tenderness to palpation over the right shoulder, trapezius, and periscapular region. Sensation was intact but diminished in the right arm. Treatment has included medical therapy with Tramadol ER, Vicodin, Tylenol #3, Percocet, and Nucynta, heat/ice therapy, and physical therapy. The treating provider has requested an H-Wave unit.

### 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 Stimulation (HWT) Page(s): 117,118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS 2009 Page(s): 117.

**Decision rationale:** H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as transcutaneous electrical nerve stimulation (TENS), in terms of its wave form. While H-wave stimulation may be performed by physicians, physiatrists, chiropractors, or podiatrists, H-wave devices are also available for home use. H-wave stimulation has been used for the treatment of pain related to a variety of etiologies, such as diabetic neuropathy, muscle sprains, temporomandibular joint dysfunctions, or reflex sympathetic dystrophy. H-wave stimulation has also been used to accelerate healing of wounds such as diabetic ulcers and to improve range of motion and function after orthopedic surgery. Per California MTUS Treatment Guidelines, There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. Medical necessity for the requested item has not been established. The requested item is not medically necessary.