

<b>Case Number:</b>	CM14-0027837		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	12/19/2012
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	02/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 58-year-old female who reported an injury on 11/19/2012. The mechanism of injury was not provided. On 06/26/2014, the injured worker presented for a followup. Her diagnoses included status post adhesive capsulitis of the right shoulder, breast reconstruction. The injured worker had complaints of pain with activity, and difficulty with ADLs. On examination, there was numbness and paresthesia along the radial wrist with activities. There was edema noted to the metacarpals and wrists. Other therapies included myofascial therapy. The provider recommended an H wave unit. 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:

**Purchase of a H-Wave unit for the right wrist/hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, 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 an H wave unit is not medically necessary. The California MTUS does not recommend an H wave as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathy 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 a TENS unit. The documentation submitted for review does not address if the injured worker had tried and failed an adequate course of conservative care to include therapy, medications, or the use of a TENS unit. The provider did not state which body part the H wave unit was indicated for, or whether the unit was to be purchased or rented in the request as submitted. A current clinical note was also not submitted for review. As such, medical necessity has not been established.