

<b>Case Number:</b>	CM15-0085121		
<b>Date Assigned:</b>	05/07/2015	<b>Date of Injury:</b>	05/27/2009
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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, North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 (IW) is a 55 year old female who sustained an industrial injury on 05/27/2009. She reported shoulder and back pain. The injured worker was diagnosed as having rotator cuff syndrome, sprain shoulder/arm, not otherwise specified, reflex sympathetic dystrophy upper limb, sprain lumbar region, lumbosacral neuritis not otherwise specified, thoracic /lumbar disc displacement, prolonged post -traumatic stress, insomnia and other disorders, psychic factor with other disorders, depressive psychosis-moderate, depressive psychosis-severe. Treatment to date has included two left shoulder arthroscopic surgeries (2012 and 2013), bilateral lumbar facet injections atL4-L5 and L5-S1, and medication management with a pain specialist. Currently, the injured worker complains of decreased ability to perform activities of daily living and decreased range of motion with tenderness to palpation and positive crepitus with range of motion in the right lower extremity. The right shoulder has crepitus with range of motion which is decreased in all planes. A purchase of a H-wave unit is requested as the unit that was in use is no longer functional.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**H-wave unit for home use:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118.

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

**Decision rationale:** CA MTUS states that HWT is not recommended as an isolated intervention, but a one month home trial of HWT may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following the failure of initially recommended conservative care. There is not adequate documentation that the patient is participating in a program of functional restoration to justify continued use of HWT. A one month trial could be considered along with proper documentation to determine medical necessity for continued use of HWT. At this time the request is not medically necessary.