

<b>Case Number:</b>	CM15-0014517		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	07/28/2014
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	12/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/26/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 male who sustained an industrial injury on 07/28/2014. The current diagnosis includes pain in joint, hand. Treatments to date include medications and surgery. Report dated 11/25/2014 noted that the injured worker presented with complaints that included pain and impaired ability to perform activities of daily living. Objective finding following the trial use of the H-wave unit included eliminating the need for oral medications, increased activity and improved function. An H-wave usage report dated 11/25/2014 was included for review. The utilization review performed on 12/26/2014 non-certified a prescription for home H-wave device purchase/indefinite use based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS and ACOEM guidelines in making this decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Horne H-Wave Device Purchase/Indefinite Use:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Durable Medical Equipment Page(s): 119.

**Decision rationale:** Horne H-wave device purchase/Indefinite use is not medically necessary. Per MTUS, H-wave "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." As it relates to this case H-wave was recommended as solo therapy for pain associated with the shoulders. Per MTUS and the previously cited medical literature H-wave therapy is not medically necessary as solo therapy and her current diagnoses.