

<b>Case Number:</b>	CM13-0018377		
<b>Date Assigned:</b>	11/08/2013	<b>Date of Injury:</b>	09/02/1992
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	08/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### 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 California. 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 (IW) is a 66-year-old female who was injured on September 2, 1992 when she slipped on a bathroom floor at work. As she attempted to get up, she slipped again sustaining injury to her right shoulder. She also sustained a basal fracture. Pursuant to a progress note dated April 2, 2013, the IW was 4 days post-op left total knee arthroplasty for osteoarthritis of the left knee. The IW states pain is controlled, no chest pain or shortness of breath. Objective physical findings revealed no tenderness to palpation, and the surgical site was clean, dry and intact. The IW is able to move extremities without difficulty. The plan was to transfer to a skilled nursing facility for 5 days for physical therapy and occupational therapy. There was no mention of home H-wave device purchase in the clinical notes submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HOME H-WAVE DEVICE FOR THE LEFT KNEE, PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H wave Device Page(s): 117-118. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, H Wave Device

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Home H wave device for left knee, purchase is not medically necessary. H wave stimulation (HWT) is not recommended as an isolated intervention for chronic pain. There is insufficient evidence to recommend the use of H wave stimulation for the treatment of chronic pain as no high-quality studies on this topic were identified. The ODG contains selection criteria that should be documented by the medical care provider for HWT to be determined to be medically necessary. See guidelines for criteria. A one month initial trial will permit the physician and physical therapy provider to evaluate any effects and benefits. In this case, the injured worker is a 66-year-old woman with a date of injury September 2, 1992. The guidelines state HWT is not recommended as an isolated intervention for chronic pain. There is insufficient evidence to recommend the use of HWT because of the lack of high-quality studies on this topic. Additionally, one month trial will permit the physician and physical therapy provided to evaluate the effects and benefits. There was no one-month trial recommended or performed for this injured worker. The treating physician requested the H wave device for purchase. Consequently, Home H wave devise left knee for purchase is not medically necessary.