

Case Number:	CM13-0040416		
Date Assigned:	12/20/2013	Date of Injury:	02/24/2011
Decision Date:	02/20/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 57 years old male with stated date of injury of 2-24-2011. The claimant has worked for the [REDACTED] for 35 years. He was last employed as a fire captain. During that- time he was required to perform the usual duties of a fireman which included fighting fires and .taking care of fire victims. In the process, he developed right knee problems.. He had a cumulative trauma claim on a Worker's Compensation basis for the right knee. He developed degenerative arthritis and this was confirmed with MRI's. He ultimately required a total knee replacement. This was complicated by postoperative stiffness and on March 14, 2012, he underwent a manipulation under. general anesthetic. After this, he had recurrent effusions. These were evaluated and an infection was ruled out. A bone scan was consistent with synovitis of the knee. [REDACTED] has recommended arthroscopic evaluation with a biopsy and synovectomy.- [REDACTED] has been referred here for a second orthopaedic opinion as to- the appropriate treatment of his- recurrent right knee effusions. Physician progress report dated 12/12/12 states that the claimant remains the same after a right total knee replacement. Current pain intensity is rated 5-6/10 which is primarily associated with swelling. Every time the claimant has had a knee aspiration, the knee has been slightly hemorrhagic and continues to have spontaneous hemarthrosis which is consistent with pigmented villonodular synovitis. On examination of the right knee, there is a large effusion and pain with ambulation. The patellar is tracking centrally and tenderness is noted over the medial and lateral retinacula. Range of motion is at 0-130 degrees. There is 4+/5 weakness in the quadriceps. Treatment plan includes arthroscopic versus open synovectomy as well as sclerosing agents, overnjght stay in the hospital, physical therapy and contrast compression therapy device rental for 14 days. The claimant has had a right total knee rep

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave Device, one month rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines H-Wave Page(s): 117 to 118.

Decision rationale: The Physician Reviewer's decision rationale: CA-MTUS (Effective July 18, 2009) page 117 to 118 of 127, section on H-Wave Stimulations states: Not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006). ACOEM guidelines state: H-wave stimulation is considered a type 'of electrotherapy. Proponents believe it penetrates more deeply with lower currents than other forms of electrotherapy. As with other forms of electrotherapy, theory holds that these electrical currents stimulate healing. A common belief is that these therapies, when of sufficient magnitude to be perceived, result in distraction from the painful site through the provision of other stimuli. Recommendation: H-wave stimulation for Treatment of Low back pain. H-wave simulation is not recommended for acute, sub-acute, or chronic lower back pain or radicular pain syndromes. Strength of Evidence- Not Recommended, Insufficient Evidence (I) There is no current program of evidence-based functional restoration as recommended by the guidelines documented by the rendering provider, hence the request for H-Wave Unit is not medically necessary.