

<b>Case Number:</b>	CM14-0024682		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	08/23/2012
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 is a 69 year old female who reported an injury on 08/23/2012. The mechanism of injury was not provided. The injured worker had an orthopedic exam on 04/08/2014 to follow up on her left shoulder arthroscopic rotator cuff repair on 03/27/2014. She complained of moderate aching, throbbing pain. Her medication list consisted of Naproxen and Ultram. The injured worker had an exam with her primary care physician on 05/07/2014 where she reported a decrease in the need for oral medication due to the use of the H-wave device. She also reported an increase of function as well. The report stated the injured worker had not sufficiently improved with conservative care and had shown to benefit from the use of the H-wave unit. The request for authorization was signed 05/07/2014.

### 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 THREE (3) ADDITIONAL MONTHS FOR THE LEFT KNEE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

**Decision rationale:** The request for home H-wave device for three additional months to left knee is non-certified. The injured worker had rotator cuff to left shoulder repair on 03/27/2014. The physician note did not have a diagnosis regarding the left knee. There was not consistency provided in the documentation as to what body part the injury was at. The California MTUS Guidelines state that the H-wave is not recommended as an isolated intervention, but as a one-month home-based trial. It is recommended in adjunct to a program of evidence-based functional restoration, following failure of physical therapy, exercise, medications and a transcutaneous electrical nerve stimulator. Although the record stated H-wave was improving pain level and function, there is no evidence of home exercise, pain assessment and evaluation, nor the use of a transcutaneous electrical nerve stimulation. Therefore the request for the home H-wave unit is non-certified.