

<b>Case Number:</b>	CM14-0212545		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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

Certification(s)/Specialty: Physical Medicine & Rehabn

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 55 year-old patient sustained an injury on 5/1/14 while employed by [REDACTED]. Request(s) under consideration include Home H-Wave Device. Diagnoses include Left knee sprain/meniscal tear s/p left knee arthroscopy, meniscectomy and chondroplasty. Conservative care has included medications, therapy modalities, home exercise, and modified activities/rest. The patient continues to treat for chronic ongoing symptom complaints. Reports of 10/8/14 and 11/24/14 from the provider noted continued left knee pain with impaired ADL. Exam showed left knee without swelling; mild crepitance in patellofemoral compartment with knee motion; range of flex/ext 0-125 degrees; intact ligament without tenderness. It was noted H-wave provided 80% reduction in pain with increased function and eliminating oral medication. The request(s) for Home H-Wave Device was non-certified on 12/11/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-Wave Device:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Transcutaneous Electrotherapy, H-Wave Stimulation Page(s): 115-118.

**Decision rationale:** Therapist note dated 10/21/14 reported TENS did not provide any subjective relief or objective benefit; however, without specific details of treatment duration/ frequency and failure. The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Trial periods of more than one month should be justified by documentation submitted for review; however, there is no documentation the patient has undergone trial use nor is there any documented consistent pain relief in terms of specific decreasing medication dosing and clear specific objective functional improvement in ADLs demonstrated. No detailed trial treatment of TENS unit with failure has occurred nor any outcome from functional restoration approach been identified. The Home H-Wave Device is not medically necessary and appropriate.