

Case Number:	CM15-0183092		
Date Assigned:	09/24/2015	Date of Injury:	12/09/2013
Decision Date:	11/09/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/17/2015

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: California, North Carolina
 Certification(s)/Specialty: Family Practice

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 50 year old female with an industrial injury date of 12-09-2013. Medical records reviewed indicate she is being treated for right posterior horn and root medial meniscus tear with extrusion, mild to moderate osteoarthritic change medially, effusion and several ganglion cysts, left knee complex tear of the posterior horn and root of the medial meniscus partially extruded from the joint space, moderate osteoarthritic change of the medial tibiofemoral compartment, effusion and popliteal cyst, left knee arthroscopy, partial medial meniscectomy, chondroplasty medial femoral condyle and medial tibial plateau, loose body removal (05-12- 2014) and right knee arthroscopy, anterior synovectomy, partial medial meniscectomy, chondroplasty medial femoral condyle and medial tibial plateau as well as patella(01-14-2015). Subjective complaints (08-06-2015) included low back pain and bilateral lower extremity pain rated as "10 out of 10". The injured worker was 15 months out form her left knee surgery and 7 months out from her right knee surgery. Physical exam (08-06-2015) of bilateral knees noted mild medial and lateral joint lint tenderness in the right and left. Range of motion is documented as right knee extension 0 degrees and left knee - 10 degrees, flexion of right knee is documented at 110 degrees and left knee as 90 degree. In the 08-13-2015, treatment note the treating physician documented the following regarding H-Wave. "Patient has reported the ability to perform more activity and greater overall function due to the use of the H wave device." Patient has given examples of increased function due to H-Wave: "Walk farther, sleep better, more family interaction, unit has helped in sleeping and I'm able to sleep 6 hours." "Before I was only getting 2 hours of sleep and now I'm getting 6 hours of sleep." "The patient is utilizing the home H wave 2 times per day, 7 days per week, 45 plus minutes per session." Prior

treatment included TENS unit, physical therapy and home exercises. Other treatments included left knee surgery with 12 sessions of post-operative therapy which were not beneficial, injections in the left knee, right knee surgery with 18 post-operative physical therapy sessions and trial of H Wave. The treatment request is for home H-Wave device for purchase. On 08-31-2015 the request for home H-Wave device for purchase was non-certified by utilization 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 purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) H-wave therapy (HWR).

Decision rationale: ODG states that H-wave therapy (HWT) is not recommended as an isolated intervention for chronic pain, but a 1 month home based trial may be considered as a noninvasive conservative option. There is insufficient evidence to recommend the use of HWT for the treatment of chronic pain as no high quality studies on this topic exist. In this case, a lack of objective, quantifiable functional improvement, improvement in ADLs, reduction in work restrictions, and decreased dependency on medications is not identified. Thus, the request for HWT does not meet criteria and is not medically necessary or appropriate.