

<b>Case Number:</b>	CM14-0123423		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	10/30/2011
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 Nevada. 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 records presented for review indicate that this 49 year-old female was reportedly injured on 10/30/2011. The mechanism of injury is noted as chasing a loose horse and fell, injuring her right shoulder and left knee. The claimant underwent right shoulder arthroscopic surgery on 5/21/2012 and left knee medial meniscectomy on 2/6/2012. The most recent progress notes dated 5/29/2014 and 8/6/2014 indicate that there were ongoing complaints of left knee and right shoulder pain. Physical examination of the right shoulder demonstrated slight deltoid wasting with slight scapular winging; range of motion: IR 0, ER 70, FF 160, extension 40, abduction 130 and adduction 35; positive impingement finding with painful arc. Examination of the left knee reveals diminished vastus medialis obliquus with capsular thickening and widening of the condyles with evident osteoarthritis deformans; increased excursion to the anterior drawer test; marked patella femoral crepitation; tenderness to suprapatellar, parapatellar, patella ligament and joint line; positive dynamic patellar compression test; range of motion: extension -15 and flexion 130. No recent diagnostic imaging studies available for review. Previous treatment includes physical therapy, knee bracing, TENS unit, and medications. A request had been made for Home H-Wave Device (purchase), which was not certified in the utilization review on 7/14/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-wave device, purchase:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation, TENS (transcutaneous electrical nerve stimulat.

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

**Decision rationale:** MTUS treatment guidelines support H-Wave stimulation (HWT) as a non-invasive conservative option for chronic soft tissue inflammation if used as an adjunct to an evidence-based functional restoration program and only after failure of conservative treatment to include physical therapy, medications, and Transcutaneous Electrical Nerve Stimulation (TENS). The claimant suffers from right shoulder and left knee pain after a work-related injury in 2011. The claimant reported improvement in her pain, an increase in function to include participation in directed exercise and stretching program, and a decrease in medications with a 30 day trial of HWT. The claimant has used a TENS unit for the past 2 years without objective improvement or meaningful subjective relief after right shoulder surgery in 2012. The California MTUS treatment guidelines support a TENS unit for postoperative pain. Given the new documentation provided, the claimant appears to meet the guideline criteria for HWT and this device is considered medically necessary.