

<b>Case Number:</b>	CM14-0218152		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	11/24/2010
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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 & Rehabilitation, Pain Management

### 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 patient is a 58 year old female who sustained a work related injury to her right shoulder, right buttocks and right hip on November 24, 2010. Mechanism of injury was noted as a trip and fall. The injured worker underwent arthroscopic right rotator cuff repair, subacromial decompression, Mumford procedure, superior labral debridement and biceps tendon debridement of the right glenohumeral joint space on May 20, 2011. On September 30, 2011 a right knee arthroscopic partial medial meniscectomy and synovectomy was performed. Physical therapy followed the procedures. Other pertinent medical/surgical history includes right nephrectomy, hypertension and morbid obesity. The patient continues to experience right shoulder, low back pain and right knee pain. Past treatment modalities include physical therapy, epidural steroid injection (ESI) to the right knee, shoulder and lumbar area with minimal lasting benefit and medications. The injured worker is considered Permanent & Stationary (P&S) and has not worked since September 2011. The physician requested authorization for Purchase of Home H-Wave Device as an outpatient. On December 4, 2014 the Utilization Review denied certification for the Purchase of Home H-Wave Device as an outpatient. Citations used in the decision process were the Medical Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines, H-Wave stimulation (HWT) criteria and recommendations.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Home H-Wave Device as an outpatient:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

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

**Decision rationale:** Regarding the request for H-wave unit, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-wave stimulation is 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, 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation submitted, the patient has undergone 17 days of H-wave trial to help reduce medication use as the patient has a history of underlying kidney disease. A progress note on 10/1/2014 documented reduction in tenderness of shoulder region, improved function, and reduced medication usage with the H-wave device. However, within the documentation submitted, there is no indication that the H wave unit is being used as an adjunct therapy to an evidenced based functional restoration program. Furthermore, the patient has only used H-wave unit for 17 days, and has not yet completed the 30 day trial as recommended by the guidelines. As such, the currently requested H wave device is not medically necessary.