

Case Number:	CM13-0062487		
Date Assigned:	04/30/2014	Date of Injury:	06/12/2008
Decision Date:	06/12/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	12/06/2013

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 California. 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 67 year old female who reported an injury on 06/12/2008. The mechanism of injury was not provided in the clinical documentation. The injured worker underwent a left total knee replacement on 04/23/2013. The injured worker reported continued pain and inability to take pain medication due to reaction causing vomiting and itching. Per the operative note dated 06/11/2013 the injured worker underwent left knee arthro-fibrosis and manipulation as a result of scar tissue. The injured worker refused lysis of the adhesions at that time. Per the physical therapy note dated 07/23/2013 the injured worker's range of motion improved with therapy. Left knee extension and flexion on 06/12/2013 were -17 and 70 actively and were -12 and 80 passively. On 07/23/2013 left knee extension and flexion were -5 and 100 actively, and -3 and 110 passively. The request for authorization for medical treatment was not included in the clinical documentation.

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 H-WAVE STIMULATION (HWT).

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines note H-wave 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). A one-month HWT trial may 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. There was insufficient documentation regarding the use of the H wave unit. There was insufficient objective data regarding functional improvement or pain control during the one month trial. In addition, there was insufficient documentation regarding physical therapy improvements while using the unit. There was a lack of documentation that a (TENS) transcutaneous electrical nerve stimulation unit has been tried although there was documentation that one had been requested. Therefore, the request for a home H-wave unit is not medically necessary.