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| Case Number: | CM14-0100461 | | |
| Date Assigned: | 07/30/2014 | Date of Injury: | 07/02/2013 |
| Decision Date: | 09/18/2014 | UR Denial Date: | 06/13/2014 |
| Priority: | Standard | Application Received: | 06/30/2014 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine 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 patient is a 37 years old male with an injury date on 07/02/2013. Based on the 05/21/2014 progress report provided by [REDACTED], the diagnoses are: 1. Left wrist pain with stiffness. 2. Left de Quervain's tenosynovitis nearly resolved. 3. Interarticular distal radial fracture. 4. Left TFCC tear. According to this report, the patient complains of left wrist pain and left forearm atrophy. Measurement of the left forearm is 26.5cm and the right forearm is 29cm. Range of motion of the left wrist is decreased. Tenderness to palpation is noted at the wrist joint. The 05/01/2014 report indicates the patient had a "30 minutes trial of H wave" and noted "reduction of pain from 8/10 to 0/10." There were no other significant findings noted on this report. The utilization review denied the request on 06/13/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 09/16/2013 to 07/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave for indefinite use: 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 H-wave stimulation (HWT) Page(s): 117,118.

Decision rationale: The requested treatment/service is not medically necessary according to the 05/21/2014 report by [REDACTED] this patient presents with left wrist pain and left forearm atrophy. The treating physician is requesting H-wave for indefinite use. There is indication that the patient has tried noninvasive conservative care of physical therapy. However, there were no indication that the patient has tried TENS unit and medications as required by MTUS. Regarding H wave units, MTUS guidelines pages 117, 118 supports a one-month home-based trial of H-Wave treatment as a noninvasive conservative option for 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 (TENS). For home use, functional benefit including medication reduction must be documented. In this case, the patient appears to have not tried the 30 days trial of H-wave unit therefore, this request is not medically necessary.