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| Case Number: | CM14-0109124 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 05/22/2012 |
| Decision Date: | 08/29/2014 | UR Denial Date: | 06/30/2014 |
| Priority: | Standard | Application Received: | 07/14/2014 |

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 & 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 44-year-old female with a date of injury of 05/22/2012. The listed diagnosis per [REDACTED] is left wrist TFCC debridement. According to progress report 05/01/2014, the patient presents with bilateral wrist pain, swelling, and stiffness. The patient states stiffness comes and goes depending on activity. The patient has participated in 2 physical therapy sessions and is requesting a refill of compound topical cream. Report 05/14/2014 indicates the patient complains of pain and exhibits impaired activities of daily living. Treater is requesting authorization of treatment with H-wave home care system for the left wrist. The treater is requesting a purchase of the unit to reduce or eliminate pain, reduce oral medication, decrease muscle spasm, and improve functional capacity. Treatment is recommended for 2 times per day at 30 to 60 minutes per treatment. Treatment history includes physical therapy, medication, and injections. Utilization review denied the request for H-wave unit on 06/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Unit Left Wrist 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: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Chronic Pain Medical Treatment Guidelines H-wave stimulation (HWT) (pp117,118).

Decision rationale: This patient presents with continued bilateral wrist pain. The treating physician is requesting a purchase of an H-wave unit for the left wrist. Per MTUS Guidelines, H-wave is not recommended as an isolated intervention but a one-month home base trial of H-wave stimulation may be considered as a non-invasive 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 initial recommended conservative care. The medical file provided for review includes progress reports from 11/13/2013 to 05/14/2013. The medical file does not show that this patient has tried a TENS unit as required by MTUS. Therefor the request for H-Wave Unit Left Wrist Purchase is not medically necessary.