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| Case Number: | CM14-0123040 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 11/09/2011 |
| Decision Date: | 09/11/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 08/01/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 56-year-old male who has submitted a claim for lumbar disc bulge, s/p left knee surgery, s/p right knee surgery, left ankle/foot strain, cervical disc bulge, thoracic strain, right elbow strain, left elbow strain, and cephalgia associated with an industrial injury date of 11/09/2011. Medical records from 05/31/2012 to 04/01/2014 were reviewed and showed that patient complained of upper back pain (grade not specified) and bilateral knee pain (grade not specified). Physical examination of the thoracic spine revealed normal findings. Physical examination of bilateral knees revealed well-healed arthroscopic sites. Tenderness upon palpation over the patellofemoral joint and medial joint space and crepitation of both knees were noted. Limited bilateral knee ROM was noted. McMurray's test and patella apprehension test were negative bilaterally, MRI of the left knee dated 05/16/2012 revealed slight bony spur involving medial and lateral femoral condyle and mild degenerative change of patellofemoral joint. MRI of the right knee dated 2012 revealed chondromalacia patellae. Treatment to date has included left knee arthroscopic partial medial and lateral meniscectomy, patellofemoral condyle chondroplasty, extensive three-compartment synovectomy/debridement, hypertrophic synovial plica resection and insertion of pain pump (08/17/2012), right knee arthroscopic partial medial and lateral meniscectomy, patellofemoral condyle chondroplasty, extensive three-compartment synovectomy/debridement, hypertrophic synovial plica resection and insertion of pain pump (02/15/2013), Synvisc injection, left knee (11/19/2012) and right knee (2013) and physical therapy. Utilization review dated 07/15/2014 denied the request for purchase H-wave device for thoracic spine and bilateral knees because there was no documentation of a failed TENS trial in the submitted records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase - H-Wave Device for thoracic Spine and Bilateral Knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation Page(s): 117-120.

Decision rationale: According to pages 117-120 of CA MTUS Chronic Pain Treatment Guidelines, H-Wave stimulation is not recommended as a primary treatment modality, but a one-month home-based H-Wave stimulation trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. It should be 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 trial period of the H-wave stimulation unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, there was no documentation of functional outcome from unspecified physical therapy visits. Moreover, there was no documentation of a TENS unit trial. Failure with both physical therapy and TENS is prerequisite to approval of H-wave stimulation unit trial per guidelines recommendation. The medical necessity for H-wave stimulation unit has not been established. Therefore, the request for Purchase - H-Wave Device for thoracic Spine and Bilateral Knees is not medically necessary.