

Case Number:	CM14-0132393		
Date Assigned:	08/22/2014	Date of Injury:	02/23/2005
Decision Date:	10/01/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	08/19/2014

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 and is licensed to practice in Texas. 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:

Medical Records reflect the claimant is a 47 year old male who was injured on 02/03/2005 with an unknown mechanism of injury. The patient underwent left knee arthroscopy in 2013; left knee scope partial meniscectomy chondroplasty in 2010. Prior treatment history has included physical therapy, H-wave which provided her with relief and home exercise program. Progress report dated 04/10/2014 states the patient continued to complain of left knee soreness and buckling. He reported physical therapy does not help. On exam, the left knee revealed no atrophy. There is tenderness to palpation over the medial joint line and retinaculum is tender. Reflexes are equal and symmetric at the Achilles and patellar tendons. There is crepitus present. He is diagnosed with chondromalacia of the knee, synovitis of the knee, medial meniscus tear, and osteoarthritis of the knee. The patient has been recommended for H-wave unit as it has helped in the past. Prior utilization review dated 07/22/2014 states the request for Home H-Wave Unit - purchase is denied as it is not documented whether or not it will be used in conjunction with a functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Unit - purchase: 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 Page(s): Page 117.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines (ODG) notes 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. The medical records document the claimant reports physical therapy is not helping. Further, there is an absence in documentation noting that this will be used in conjunction with a functional restoration program. Based on the Chronic Pain Medical Treatment Guidelines as well as ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.