

Case Number:	CM14-0039057		
Date Assigned:	06/27/2014	Date of Injury:	07/29/2002
Decision Date:	07/28/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/03/2014

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 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 73 year old female who was injured on 07/29/2002. The mechanism of injury is unknown. Prior treatment history included H-wave with benefit and physical therapy (completed sessions unknown). The patient underwent left carpal tunnel release in 01/2014. Progress note dated 02/18/2014 states the patient complained of worsening pain in the left hand and wrist. She notes she tried to treat herself with an H-wave unit but it is non-functional. She used warm compresses and Tramadol but they only provide her with temporary relief of her symptoms. On examination of the left minor wrist, she has tenderness over the extensor compartment, as well as over the first carpometacarpal joint. There is decreased sensation in the radial forearm extending distally to the first and second digits. Tinel's sign is negative. Phalen's test is positive eliciting numbness and tingling to the first and second digit. The left hand has palpable nodules and immobile overlying the metacarpophalangeal joints of the third and fourth digits at the palmar/flexor aspect. Range of motion of the metacarpophalangeal joint exhibits index finger flexion 90/90; middle finger flexion 80/90; ring finger flexion 75/90; little finger flexion 80/90. Pinch grip strength on the right (major) is 14/12/12; and on the left (minor) is 10/10/10. JAMAR grip strength readings on the right (Major) are 8/10/10; and on the left (minor) is 6/8/10. The patient was diagnosed with left wrist overuse, status post carpal tunnel release. The recommendations are H-wave therapy which has now become non-functional and requires replacement as well as physical therapy twice a week for 3 weeks. Prior utilization review dated 03/24/2014 states the request for Physical therapy two times per week for three weeks (2x3) is not certified as there is no indication that the patient cannot perform home exercises; therefore, medical necessity has not been established. The request for Replacement of H-wave therapy unit for home use is not certified as there are limited documented functional gains from prior

modality as the patient has used H-wave in the past; therefore, medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two times per week for three weeks (2x3): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy hands guidelines.

Decision rationale: Guidelines stated that hand PT is recommended, allowed for fading frequency plus active self-directed home PT. This patient had injury in 2002 and PT in the past. Medical records do not demonstrate why this patient needs additional PT. The medical necessity is not established.

Replacement of H-wave therapy unit for home 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 Page(s): 117 AND 118.

Decision rationale: As per CA MTUS guidelines, H-wave unit 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)." The records submitted for review fail to document evidence-based functional restoration. Therefore, the medical necessity is not established for Replacement of H-wave therapy unit for home use.