MAXIMUS Federal Services

Case Number:	CM14-0043781		
Date Assigned:	07/02/2014	Date of Injury:	02/19/2013
Decision Date:	08/22/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	04/10/2014

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 injured worker is a 57-year-old female who reported an injury on 02/19/2013. The mechanism of injury was noted to be a slip and fall. The injured worker's diagnoses were noted to be right hip and groin strain, and bilateral osteoarthritis in the knees. The injured worker's prior treatments were noted to be physical therapy, chiropractic care, acupuncture, aqua therapy, transcutaneous electrical nerve stimulation, and injections. The injured worker's diagnostics were noted to be x-rays and MRI. The injured worker's medications were noted to be Flexeril, Vicodin, Ultram, and Tylenol. A clinical evaluation on 03/19/2014 indicated the injured worker with complaints of significant hip pain with prolonged sitting and standing. The injured worker also continued to complain of bilateral knee pain. The examination noted the injured worker was significantly overweight, walking with guarding. It was noted that range of motion was limited. There was generalized tenderness over the right buttock and the right hip anteriorly. The examination of the knee joints revealed tenderness over the medial aspects of both knees, right more than left. Range of motion in the right knee joint was limited in flexion bilaterally. There was no crepitus evident. There was no instability in the knee. Anterior or posterior drawer sign was negative. The treatment plan is for right hip arthroscopic surgery. The rationale for the request was not provided within the documentation. A request for authorization for medical treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HW T) Page(s): 117-118.

Decision rationale: The request for H wave is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend H wave stimulation as an isolated intervention, but a 1 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 physical therapy and medications, plus transcutaneous electrical nerve stimulation. The injured worker's documentation does not indicate diabetic neuropathic pain. The guidelines recommend an H wave stimulation unit for chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration. However, the documentation provided for review does not indicate a plan for evidence based functional restoration. In addition, the documentation does not provide failure of initially recommended conservative care including physical therapy, medications, and transcutaneous electrical nerve stimulation. The request for H wave fails to indicate a duration of therapy and where the treatment is being applied. Therefore, the request for H wave is not medically necessary.