

Case Number:	CM14-0192538		
Date Assigned:	11/26/2014	Date of Injury:	12/15/2012
Decision Date:	01/28/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/18/2014

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 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 37 year old female with date of injury 12/27/12. The treating physician indicates in the report dated 10/23/14 (155) that the patient presents with pain affecting the left hand. The physical examination findings reveal range of motion (ROM) shoulders bilateral forward flexion is 120 degrees and bilateral abduction is 110 degrees. Manual Motor Strength Testing left elbow flexion is 4/5 and right elbow flexion is 4-/5. Pain was a 9/10 at its worse and a 10/10 at its best. Pain was constant and lasting throughout the day. Pain is exacerbated by chores at home but is relieved by medicines. Prior treatment includes physical therapy, H-Wave therapy and medications. The current diagnosis is: 1. Carpal Tunnel Syndrome 2. Bicipital Tenosynovitis 3. Lateral Epicondylitis The utilization review report dated 11/05/14 denied the request for H-wave device based on lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 98. Decision based on Non-MTUS Citation BlueCross BlueShield; TENS, Aetna & Humana; TENS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-118.

Decision rationale: The patient presents with left hand pain. The current request is for Home H-wave device. The California MTUS Guidelines state that a trial of H-Wave Stimulation (HWT) may be appropriate and any ongoing usage must be justified by documentation submitted for review. The MTUS guidelines go on to state, "The one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function." According to the treating physician report dated 9/11/14 (115) the patient had undergone H-wave therapy that provided 40%-60% relief in pain. However it also states, "the patient reports that her symptoms have gotten worse since her last visit." There is also no indication for H-wave therapy in the reports dated 10/09/14 (129) or 10/30/14 (150). In this case, the patient has been using an H-Wave for at least one month and there is no discussion found to indicate how often the unit has been used and there is no documentation that the patient experiences any functional benefit from H-Wave usage as required by the MTUS guidelines. Treatment is not medically necessary and appropriate.