

<b>Case Number:</b>	CM14-0198875		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	05/23/2014
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 Rehab, has a subspecialty in Interventional Spine 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 43 year old female with an injury date on 05/23/2014. Based on the 10/15/2014 hand written progress report provided by the treating physician, the diagnosis is right knee SP with small effusion MRI-09/2014 According to this report, the patient complains of "right knee, tender MJL>LJL, pop fossa, mild diffused swelling noted." Range of motion is 0 to 137 degrees. The 09/17/2014 report indicates patient knee pain "beginning to improve with chiro service and therapy."The treatment plan is to complete remaining chiropractic sessions, RFA, "H-wave to decrease swelling and increase range of motion as patient had good result with use in therapy." The patient work status is Temporarily Totally Disabled until 10/28/2014. There were no other significant findings noted on this report. The utilization review denied the request for Interferential unit, and 1 H-Wave on 11/01/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 05/27/2014 to 10/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential unit Page(s): 118-120.

**Decision rationale:** According to the 10/15/2014 report, this patient presents with right knee pain. The current request is for Interferential Unit. The MTUS Guidelines page 118 to 120 states that interferential current stimulation is not recommended as an isolated intervention. MTUS also recommends trying the unit for one-month before a home unit is provided if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures. In this case, the treating physician does not document that the patient is unresponsive to conservative measures or pain is ineffectively controlled with medication. The patient does not present with a specific indication as required by the guidelines for IF unit. There were no indication that the patient has trialed the unit for a month to determine effectiveness. The current request is not medically necessary.

**1 H-Wave:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to the 10/15/2014 report, this patient presents with right knee pain. The current request is for 1 H-Wave. Regarding H wave units, MTUS guidelines pages 117, 118 supports a one-month home-based trial of H-Wave treatment as a noninvasive conservative option for 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 (TENS). For home use, functional benefit including medication reduction must be documented. Review of the provided reports, the treating physician indicates that the patient has tried noninvasive conservative care of chiropractic treatment and therapy with benefit; "beginning to improve with chiro service and therapy." However, there were no indication that the patient has tried TENS unit and medications as required by MTUS. In this case, there is no documentation submitted to indicate that the patient has had a one month trial of H-Wave. Therefore, the requested H-wave device is not in accordance with the guidelines. The current request is not medically necessary.