

Case Number:	CM14-0216668		
Date Assigned:	01/06/2015	Date of Injury:	09/18/2008
Decision Date:	03/23/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/26/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62 year old male, who sustained an industrial injury on 9/18/2008. He has reported wrist pain. The diagnoses have included triangular Fibrocartilage complex tear, numbness, ulnar neuropathy, and wrist tendinitis. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesic, topical compound, wrist brace, physical therapy and home exercise. Currently, the IW complains of right wrist pain. On 11/26/14, physical examination documented tenderness over lateral and medial epicondyle and extensor muscles, Tinel's test positive. The provider documented that surgery was requested and denied. The plan of care included continuation with medications, brace, physical therapy and trial of a home H-Wave unit. On 12/9/2014 Utilization Review non-certified twelve (12) physical therapy sessions (two times weekly for six weeks) for right hand/wrist and DME: H-Wave unit thirty (30) day trial, noting the documentation did not support medical necessity. The MTUS Guidelines were cited. On 12/26/2014, the injured worker submitted an application for IMR for review of twelve (12) physical therapy sessions (two times weekly for six weeks) for right hand/wrist and DME: H-Wave unit thirty (30) day trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1-2x6 for Right Hand/Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation ODG, Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy is not medically necessary and appropriate.

DME H-Wave Unit-30 Days Trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H- Wave Stimulator Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, H-Wave Stimulation, pages 115-118; H-Wave: Not recommended as an.

Decision rationale: Per guidelines, H-wave 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). Submitted reports have not demonstrated having met these criteria and the patient is continuing with a HEP. The DME H-Wave Unit-30 Days Trial is not medically necessary and appropriate.

