

Case Number:	CM13-0019659		
Date Assigned:	04/25/2014	Date of Injury:	06/24/2009
Decision Date:	06/10/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	09/03/2013

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 underlying date of injury in this case is 06/24/2009. The patient's primary diagnosis is lumbar disc displacement. On 07/29/2013, the patient underwent a qualified medical evaluation. The evaluating physician noted that the patient had a working diagnoses of status post bone grafting, a cyst in the proximal humerus, which was non-industrial in nature, bilateral shoulder impingement syndrome, normal examination of the neck and upper extremities, normal exam of the lower extremities and low back, and obesity. The evaluating physician recommended further treatment to include medications or injections to the shoulders to control symptoms. The physician noted that the patient was poorly motivated and had psychiatric issues and these were substantially affecting her ability to return to work.

IMR ISSUES, DECISIONS AND RATIONALES

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

30 DAY EVALUATION TRIAL OF H-WAVE HOMECARE SYSTEM: 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 (HWT) Page(s): 117.

Decision rationale: The Chronic Pain Medical Treatment Guidelines indicate that a one-month trial is indicated as an option for the treatment of diabetic neuropathic pain or chronic soft tissue inflammation after failure of an initial evidence-based functional restoration program including physical therapy and medications plus transcutaneous electrical nerve stimulation (TENS). The medical records are very limited in terms of the patient's specific past treatments as the rationale for the current request for a 30-day home trial of an H-wave system. The limited information in the medical records at this time does not provide a basis to support a request for this equipment. This request is not medically necessary.