

Case Number:	CM13-0066699		
Date Assigned:	01/03/2014	Date of Injury:	02/16/2011
Decision Date:	05/19/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/16/2013

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 Occupational Medicine, 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:

This is a 48 year old female patient s/p injury 2/16/11. The patient presented 11/7/13 with complaints of pain and impaired activities of daily living. She is noted to have right shoulder pain and bilateral upper extremity pain. The 11/11/13 progress note indicates that the patient has numbness and tingling in the right upper extremity with dropping objects and nighttime awakenings due to pain. She had decreased sensation in the bilateral median and ulnar nerve distributions. There was positive Tinel's and Phalens, positive median nerve compression testing, and ulnar nerve compression testing bilaterally. She has been treated with medications, work restrictions, and therapy. There is documentation of an 11/25/13 adverse determination.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE FOR PURCHASE: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state that a one-month home-based trial of H-wave stimulation may be indicated with chronic soft tissue inflammation and when H-wave

therapy will be used as an adjunct to a method of functional restoration, and only following failure of initial conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). However, there is no clear discussion in the medical records provided for review that the H-wave is intended to be used as an adjunctive therapy. There is no discussion of functional restoration. Furthermore, there is no evidence that the patient has had as successful trial period to substantiate the medical necessitate of a purchase. There is no evidence of functional outcomes from previous use in terms of pain relief and functional gains. The request is therefore not medically necessary and appropriate.