

Case Number:	CM14-0004013		
Date Assigned:	02/03/2014	Date of Injury:	06/07/2000
Decision Date:	06/20/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/09/2014

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 injured worker is a 60-year-old female with a reported date of injury on June 07, 2000; the mechanism of injury was not provided. Diagnoses included right first dorsal compartment repair, status post de Quervain's tenosynovitis release, status post radial nerve release, focal complex region pain syndrome; type 2 in right wrist and right upper extremity. The evaluation dated December 02, 2013 noted limited function to the right upper extremity that prevented the injured worker from performing activities of daily living that included limitation of grocery shopping and minimal cooking to 5 minutes. It was also noted that the injured worker could self-groom but had difficulty shampooing and buttoning clothes. Objective findings included hypersensitivity to the right radial nerve and reduced sensation in the ulnar nerve distribution of the right hand. Additional findings included decreased range of motion of the right shoulder measured at 80 degrees of abduction and 90 degrees of flexion. It was noted that H-Wave therapy to the right upper extremity allowed an increase in function by over 50% and allowed the tapering of Opana ER 10mg from 5 tabs to 4. The request for authorization for the purchase of an H-Wave device was submitted on December 02, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE MUSCLE STIMULATOR UNIT(PURCHASE OF UNIT AND SUPPLIES) TO TREAT RIGHT UPPER EXTREMITY INCLUDING RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174, 189, Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT) Page(s): 117-118. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter and Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT), Page(s): 117-118.

Decision rationale: The request for H-Wave muscle stimulator unit (purchase of unit and supplies) to treat right upper extremity including right shoulder is not medically necessary. It was noted that the injured worker had limited function to the right upper extremity that prevented her from performing activities of daily living. Objective findings included hypersensitivity to the right radial nerve and reduced sensation in the ulnar nerve distribution of the right hand. Additional findings included decreased range of motion of the right shoulder measured at 80 degrees of abduction and 90 degrees of flexion. It was noted that H-Wave therapy to the right upper extremity allowed an increase in function by over 50% and allowed the tapering of Opana ER 10mg from 5 tabs to 4. The California MTUS guidelines state that H-wave stimulation is not recommended as an isolated intervention, but a month home based trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. There is lack of evidence within the documentation that the unit will be used as an adjunct to ongoing treatment modalities of an evidence-based functional restoration program. It was unclear if the injured worker underwent a full one month trial of h-wave therapy. As such this request is not medically necessary.