

Case Number:	CM14-0017437		
Date Assigned:	04/14/2014	Date of Injury:	03/14/2013
Decision Date:	05/30/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/11/2014

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 Anesthesiology, and is licensed to practice in Florida. 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 62 year old male who reported an injury on 03/14/2013. The mechanism of injury was not provided. Current diagnoses include osteoarthritis of the right hip and history of hip hemiarthroplasty. The injured worker was evaluated on 01/13/2014. The injured worker reported improvement in symptoms with work hardening and physical therapy. Physical examination revealed increased pain with hip flexion, 30 degrees flexion, 30 degrees internal rotation, 50 degrees passive range of motion, intact sensation, and negative straight leg raising. Treatment recommendations at that time included continuation of a work-hardening program to increase functional activities. A request for authorization was then submitted on 01/02/2014 for a home H-Wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT HIP H-WAVE DEVICE FOR HOME USE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The MTUS Chronic Pain Guidelines state H-Wave stimulation is not recommended as an isolated intervention, but a 1-month home based trial may be considered as a non-invasive conservative option. H-Wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following a failure of initially recommended conservative care. There is no evidence of a successful 1-month trial prior to the request for a purchase. There is also no documentation of a failure to respond to physical therapy, medications, and TENS therapy, as recommended by the MTUS Chronic Pain Guidelines. As such, the request for a right hip H-wave device for home use is not medically necessary and appropriate.