

Case Number:	CM14-0017670		
Date Assigned:	04/16/2014	Date of Injury:	10/29/2010
Decision Date:	06/02/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	02/12/2014

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 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:

The patient is a 55 year old female who was injured on 10/29/2010. The patient fell at work. Prior treatment history has included sacroiliac support belt, injections and physical therapy. AME report dated 09/17/2013 documented the patient with complaints of pain in the right buttock and inguinal region with pain referral into the right thigh. To a far lesser extent, the patient experiences pain in the left hip. He also complains of pain in the left knee. The objective findings on exam reveal the patient ambulates with a Trendelburg type of gait, which is bilateral. She uses a cane in the right hand. The musculature is normal in contour, without evidence of atrophy. Heel walking and toe walking are weak bilaterally. There is marked tenderness over the right sacroiliac joint. The Trendelburg tests are positive bilaterally. Reflex testing quadriceps 2+. Neurosensory examination is within normal limits. The vascular examination is within normal limits. The patient experiences bilateral hip pain, but also reports left knee pain. She was diagnosed with multiple epiphyseal dysplasia as a youth. She experienced difficulty with ambulation and underwent bilateral total hip arthroplasty in the year 1993. PR-2 dated 01/06/2014 documented the patient with complaints of pain. The patient exhibits impaired activities o daily living. The treatment plan is a EWL-H-Wave Homecare System for purchase or indefinite use.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE DEVICE FPR THE LEFT HIP, PURCHASE: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a "one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Rental would be preferred over purchase during this trial. Trial periods of more than one month should be justified by documentation submitted for review."The UR decision dated 01/16/2014 reports the patient was approved for a one month rental of the HWT for the left hip. However, the request was for purchase, and the patient appears to have already used the unit for 118 days with improvement in pain and function noted by the UR reviewer. However, the provided medical records do not document frequency of H-wave use or outcomes in terms of pain or function. The medical records also do not document that H-wave use is being combined with a program of evidence-based functional restoration. There is no discussion of chronic soft tissue inflammation for which the device is recommended. Medical necessity is not established.