MAXIMUS Federal Services

Case Number:	CM14-0019255		
Date Assigned:	04/25/2014	Date of Injury:	03/16/2013
Decision Date:	07/07/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/14/2014

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 applicant has filed a claim for chronic shoulder pain reportedly associated with an industrial injury of March 16, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; psychotropic medications; transfer of care to and from various providers in various specialties; and apparent return to work at an earlier point in the life of the claim. An earlier note of October 21, 2013 was notable for comments that the applicant had returned to regular work at that point in time.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE 3 ADDITIONAL MONTHS FOR THE RIGHT SHOULDER: Upheld

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

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

Decision rationale: As noted on page 118 of the MTUS Chronic Pain Medical Treatment Guidelines, provision of the H-Wave device beyond a one-month trial rental should be predicated on the documentation submitted for review. In this case, however, the documentation

submitted for review is sparse, thinly developed, and comprises largely of preprinted checkboxes with little or no narrative commentary. No compelling case has been made for usage of the H-Wave device in question. It is not clearly stated how prior usage of the H-Wave device specifically benefitted the applicant. Furthermore, it appears that device has been endorsed largely by the device vendor as opposed to the applicant's primary treating provider (PTP). Therefore, the request is not medically necessary, for all of the stated reasons.