

Case Number:	CM14-0129470		
Date Assigned:	08/18/2014	Date of Injury:	11/01/2001
Decision Date:	09/18/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/14/2014

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 Physical Medicine and 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 50-year-old male who reported an injury on 05/19/2010. He reportedly tripped over a buried barbed wire and fell. On 06/23/2014, the injured worker presented with pain and a stiff shoulder on the left side. Upon examination the range of motion values for the left shoulder were 145 degrees of flexion, 99 degrees of abduction, 70 degrees of internal and external rotation. There was pain with motion. The diagnosis was pain in the left shoulder. There was a prior MRI of the left shoulder with a noted positive impingement. On 01/10/2014, the injured worker underwent a left sided subacromial decompression and Mumford. Prior therapy included the use of a home H wave device and medications. The provider recommended the purchase of a home H wave device. The provider's rationale was not provided. The Request for Authorization form was dated 06/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Home H Wave device: Upheld

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

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

Decision rationale: The request for purchase of a home H wave device is not medically necessary. California MTUS Guidelines do not recommend the H wave as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathic or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care. The clinical documentation does not address any numbness or weakness to suggest neuropathic pain. Furthermore, there is lack of objective functional improvement with the prior use of the H wave device. The provider's request does not indicate the site at which the home H wave device is intended for in the request as submitted. As such, the request is not medically necessary.