

Case Number:	CM14-0172166		
Date Assigned:	10/23/2014	Date of Injury:	11/16/2010
Decision Date:	11/21/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/17/2014

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 Emergency 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 injured worker is a 62-year-old female who reported an injury on 11/16/2010. The mechanism of injury was not provided. On 03/11/2014, the injured worker presented with slightly improved left shoulder pain. She rated the pain at a 1/10 to 2/10. The injured worker has undergone acupuncture treatment with some benefit. Upon examination, the injured worker ambulated without antalgia and appeared with an unremarkable posture. Examination of the right shoulder revealed range of motion of 155 degrees of forward flexion and 125 degrees of lateral abduction. There was a lack of crepitus. Diagnoses were fracture of the humerus proximal end, bilateral hip bursitis, left shoulder mild rotator cuff strain with left AC joint tendinitis, bilateral knee degeneration, bilateral ankle asymptomatic, bilateral plantar fasciitis asymptomatic, and stress and anxiety secondary to workplace condition, improving. The provider recommended an H-Wave home device purchase. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a home H-Wave unit: 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 H-wave stimulation (HWT) Page(s): 117.

Decision rationale: The request for the Purchase of a home H-Wave unit is not medically necessary. The California MTUS Guidelines do not recommend an H-Wave as an isolated intervention. It may be considered as a noninvasive conservative option for diabetic neuropathy or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration. H-wave therapy is recommended following failure of initially recommended conservative care including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. The medical documentation did not address any numbness or weakness to suggest neuropathic pain. Furthermore, there is a lack of documentation that the injured worker had failed a trial of a TENS unit. There is no information regarding if the injured worker had an H-Wave trial and the efficacy of that trial period. The provider's request does not indicate the site at which the H-Wave stimulation unit was indicated for in the request as submitted. As such, medical necessity has not been established.