MAXIMUS Federal Services

Case Number:	CM14-0174107		
Date Assigned:	10/28/2014	Date of Injury:	09/05/2013
Decision Date:	12/04/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/23/2014

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 Illinois. 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 43-year-old male who reported an injury on 09/05/2013. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of shoulder pain, carpal tunnel syndrome, and biceps tendon rupture. Physical medical treatment consists of surgery, injections, use of an E stimulator machine, physical therapy, the use of an elbow brace, ultrasound, and medication therapy. Medications consist of Diclofenac and Norco. AP/scapular Y and axillary views of the left shoulder were ordered, performed and interpreted. They demonstrated no obvious bony injury, subluxation, dislocation, or degenerative changes. On 10/23/2014, the injured worker complained of persistent pain in the right elbow. Physical examination of the right elbow revealed a range of motion of 3 to 130 degrees, 45 degrees supination. Sensation was diminished in the thumb and index finger. There was a negative Tinel's, compression, Phalen's test, carpal tunnel. There was also negative Tinel's at the pronator. The medical treatment plan is for the injured worker to continue with physical therapy and have use of an H-wave home unit. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Home Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, H-Wave

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The request for H-wave home unit is not medically necessary. According to the MTUS Guidelines, H-wave devices are not recommended as a primary treatment modality. It was documented in the submitted report that the injured worker had undergone physical therapy. However, it was not specified if the injured worker was continuing with physical therapy. Additionally, the progress note dated 10/23/2014 lacked any pertinent physical findings regarding range of motion, sensory deficits, or functional deficits. There was also no indication of whether the H-wave unit was currently being used by the injured worker, nor the efficacy of the unit. Furthermore, guidelines recommend a trial run total of 1 month of the unit before purchase. The request as submitted did not specify whether the H-wave unit was for purchase or for rental. Given the above, the injured worker is not within the MTUS recommended guideline criteria. As such, the request is not medically necessary.