

Case Number:	CM14-0023815		
Date Assigned:	06/11/2014	Date of Injury:	06/13/2012
Decision Date:	07/15/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	02/25/2014

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 Orthopedic Surgery, and is licensed to practice in Texas. 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 63-year-old female who reported an injury on 06/13/2012. The mechanism of injury was not provided. A clinical note dated 11/25/2013 noted the injured worker presented with right shoulder pain. She stated that her shoulder pain worsened when she had to reach overhead or when she lied on her right arm. She continued to note weakness in the right hand and episodes of her arm turning blue and mottled. Prior treatment included H wave therapy, medications, and she was pursuing herbal treatment which she had researched on the internet. Upon examination, the wrist demonstrated significantly improved range of motion in flexion and extension. The swelling had subsided. The scars were softening. The distal radioulnar joint appeared stable. The anterior lateral acromion was tender. Shoulder range of motion was painful. There was a positive Hawkins sign, a positive Neer sign, and a positive drop arm test. The diagnoses included complex regional pain syndrome of the right wrist and right shoulder impingement syndrome. The provider requested a home H-wave device for a 6 month rental. 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:

HOME H-WAVE DEVICE 6 MONTH RENTAL QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (Hwt) Page(s): 116.

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

Decision rationale: The request for a home H wave device 6 month rental with a quantity of 1 is non-certified. The California MTUS Guidelines do not recommend H-wave therapy as an isolated intervention, but a one month home based trial may be considered as a noninvasive conservative option for neuropathic pain 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, including physical therapy and medications, plus transcutaneous electrical nerve stimulation. The efficacy of the injured worker's previous courses of conservative care was not provided. Although the provider stated there was significant improvement with range of motion, baseline values were not provided to verify improvements. The length of time that the injured worker used H wave therapy was not provided. The provider's request did not indicate the site which the H wave device was intended for. In addition, the request for a 6 month rental exceeds the guideline recommendations of a one month trial. As such, the request is non-certified.