

Case Number:	CM14-0067389		
Date Assigned:	07/11/2014	Date of Injury:	08/21/2012
Decision Date:	09/18/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/12/2014

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 Anesthesiology, has a subspecialty in Pain 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 41-year-old male who sustained an injury to his right shoulder on 08/21/12. Mechanism of injury was not documented. Prescription note dated 03/19/14 reported that with Transcutaneous Electrical Nerve Stimulation (TENS) unit failed and did not provide adequate relief. There were no objective benefits when the injured worker was using TENS unit. The injured worker was recommended a home H-wave unit. Progress report dated 03/28/14 indicated that the injured worker was status post right shoulder rotator cuff repair with biceps tenodesis and superior labral tear from anterior to posterior debridement on 12/15/13. Patient compliance and outcome report dated 04/13/14 reported that 12 days of use with the H-wave unit provided the patient 40% relief. A progress report dated 04/22/14 reported that the injured worker continued to complain of pain and exhibit impairment in activities of daily living. The injured worker reported the ability to perform more activity and greater overall function due to H-wave device. Treatment plan included purchase of home H-wave device and system for two times a day times 30-60 minutes per treatment as needed. It was reported that the injured worker had not sufficiently improved with conservative care and the trial of home H-wave had shown benefit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home H-wave unit.

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

Decision rationale: Previous request was denied on the basis that there was no clear presentation as to how this request would impact the functional status in a positive manner. There is limited documentation from the treating provider that the use of the unit has made any significant change in the functional status (i.e., increase in total number of hours able to work, number of hours worked in a shift, or increase in weight lifting. Considering this and without clear evidence of an aggravation, exacerbation, or other clearly defined extenuating circumstance, the requested H-wave unit is not supported. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information that would support reversing the previous adverse determination. Given this, the request for home H-wave purchase is not indicated as medically necessary.