

Case Number:	CM14-0084520		
Date Assigned:	07/23/2014	Date of Injury:	02/18/2011
Decision Date:	10/15/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/06/2014

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 & 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 43-year-old male who reported an injury on 02/18/2011. The mechanism of injury was not submitted for clinical review. The diagnoses included status post right shoulder arthroscopic surgery, impingement syndrome of shoulder and cervical spine myofasciitis with radiculitis. The previous treatments included medication, H wave and surgery. In the clinical note dated 07/01/2014 it was reported the injured worker complained of shoulder and neck pain. The injured worker complained right shoulder had constant pain. The injured worker reported the left shoulder had slight pain that comes and goes. The physical examination the provider noted the injured worker had tenderness at the right sacroiliac joint. The provider indicated that the injured worker's shoulders were uneven, he noted the right shoulder was lower than the left. The injured worker had limited range of motion of the shoulders. The injured worker had a positive impingement test. The request submitted is for a home H wave device for purchase. However, rationale is not provided for clinical review. The Request for Authorization was submitted and dated on 06/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave device and system, purchase: Upheld

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

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

Decision rationale: The request for Home H-Wave device and system, purchase is not medically necessary. The California MTUS Guidelines does not recommend the 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, only following failure of initially recommended conservative care, including recommended physical therapy and medication, plus transcutaneous electrical nerve stimulation. There is lack of documentation indicating the injured worker had tried and failed on conservative therapy including physical therapy and medications. There is lack of documentation indicating the injured worker underwent an adequate trial of a TENS unit. Therefore, the request is not medically necessary.