

Case Number:	CM14-0093464		
Date Assigned:	07/25/2014	Date of Injury:	02/29/2012
Decision Date:	08/29/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/19/2014

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, has a subspecialty in Pain Management 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:

This is a male patient with the date of injury of February 29, 2012. A Utilization Review was performed on May 22, 2014 and recommended non-certification of a home H-wave device. A Progress Report dated April 29, 2014 identifies Subjective complaints of a burning sensation on his right shoulder, which radiates up into his neck and into his upper back. Objective findings identify decreased shoulder range of motion with positive end range pain with active motion. Diagnosis identify status post right shoulder arthroscopic rotator cuff repair, subacromial decompression and anterior acromioplasty, distal clavicle excision, flared right shoulder pain, probably cervicogenic, and cervical spine sprain/strain. Treatment Plan identifies diagnostic ultrasound, chiropractic therapy pending, refill medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase H-wave Device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Stimulation Page(s): 117-118. Decision based on Non-MTUS Citation Blue Cross Blue Shield, 2007; Aetna 2005.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 117-118.

Decision rationale: Regarding the request for H-Wave unit, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-Wave stimulation is not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic 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 recommended physical therapy and medications plus transcutaneous electrical nerve stimulation. Within the documentation available for review, there is no indication that physical therapy has been attempted. Additionally, it is unclear whether the patient underwent a 30 day TENS unit trial as recommended by guidelines. There is no statement indicating how frequently the tens unit was used, and what the outcome of that tens unit trial was for this specific patient. Additionally, there is no documentation that the patient has had a successful H-wave trial with documentation of analgesic response and objective functional improvement. In the absence of such documentation, the currently requested H- Wave device is not medically necessary.