

Case Number:	CM15-0141844		
Date Assigned:	07/31/2015	Date of Injury:	09/12/2013
Decision Date:	08/31/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 64 year old female, who sustained an industrial injury on 9-12-13. Initial complaints were not reviewed. The injured worker was diagnosed as having shoulder upper arm sprain-strain; swelling of limb; Somatic Dysfunction upper extremity. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 6-3-15 indicated the injured worker reported having increased loss of strength in the left arm, loss of sleep and depression with no authorization of appeals. Objective findings document positive left shoulder MRI with 2 tears (no date). It is also noted she has positive cervical disc and trigger points with loss of motion of the cervical spine on the right. His treatment plan includes a referral for surgery on the left shoulder due to functional losses and chiropractic sessions with pain management referral. The submitted documentation includes the trial notes and information regarding the H-wave device. The provider is requesting authorization of a Home H-wave device for purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave device for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement, H-wave stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 117-118 of 127.

Decision rationale: Regarding the request for H-wave unit, Chronic Pain Medical Treatment Guidelines cite 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 there is no indication of a condition for which H-Wave is supported and failure of a one-month formal TENS trial including notation of how frequently the TENS unit was used and outcomes in terms of pain relief, function, and medication usage. In the absence of such documentation, the currently requested H-wave unit is not medically necessary.