

Case Number:	CM15-0183508		
Date Assigned:	09/24/2015	Date of Injury:	12/01/2014
Decision Date:	10/29/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/17/2015

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

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 39-year-old male who sustained an industrial injury on 12-1-14. The injured worker reported pain in the neck and right shoulder. A review of the medical records indicates that the injured worker is undergoing treatments for rotator cuff syndrome, cervical spine disc degeneration. Medical records dated 10-1-15 indicate "constant neck pain". Provider documentation dated 10-1-15 noted the work status as return to modified work 10-1-15. Treatment has included Tramadol since at least December of 2014, right shoulder magnetic resonance imaging (2-18-15), transcutaneous electrical nerve stimulation unit, at least 12 visits to physical therapy, injection therapy, Relafen since at least June of 2015, and Flexeril since at least June of 2015. Objective findings dated 10-1-15 were notable for neurovascular examination noted to be intact, loss of neck extension with positive impingement sign. The original utilization review (8-24-15) denied a request for Home H-Wave Device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-Wave Device: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Trial periods of more than one month should be justified by documentation submitted for review; however, it is not clear what benefit or outcome has been achieved without any documented consistent pain relief in terms of decreased medication dosing, decreased medical utilization, and clear specific objective functional improvement in ADLs by any H-wave treatment trial nor has submitted report demonstrated failed TENS unit been demonstrated. The patient continues with chronic ongoing pain with unchanged clinical findings without plan for active treatment towards a functional restoration approach. The Home H-Wave Device is not medically necessary or appropriate.