

Case Number:	CM15-0212318		
Date Assigned:	11/02/2015	Date of Injury:	02/06/2014
Decision Date:	12/18/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/28/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 35 year old male sustained an industrial injury on 2-6-14. Documentation indicated that the injured worker was receiving treatment for right bicep tendonitis, right shoulder labrum rupture and right shoulder impingement syndrome. The injured worker underwent right shoulder arthroscopy with anterior labral reconstruction and biceps tenodesis on 6-22-15. The injured worker received postoperative physical therapy, medications and a trial of a home H-wave system. In a PR-2 dated 8-20-15, objective findings included "improving" right shoulder range of motion and "increased" strength. The treatment plan included continuing physical therapy. In a PR-2 dated 9-29-15, the injured worker reported that the H-wave device allowed him to eliminate the need for oral medications with improved function and improved ability to perform activities of daily living. The treatment plan included requesting authorization for a home H-wave device. On 10-7-15, Utilization Review noncertified a request for a home H-wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Home H-Wave device: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction, Functional improvement measures, Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic H-wave stimulation (HWT)).

Decision rationale: The injured worker sustained a work related injury on 2-6-14. Documentation indicated that the injured worker was receiving treatment for right bicep tendonitis, right shoulder labrum rupture and right shoulder impingement syndrome. . Treatments have included right shoulder arthroscopy with anterior labral reconstruction and biceps tenodesis postoperative physical therapy, medications and a trial of a home H-wave system. The medical records provided for review do indicate a medical necessity for Purchase of Home H-Wave device . The medical records indicate the injured worker had marked improvement in pain that he no longer needed to use Norco. Consequently, the use of the equipment satisfied the MTUS definition of Functional Improvement, which is defined as, "either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment." While not recommended as an isolated intervention, the MTUS and the Official Disability Guidelines recommends it use if the patient meets the following criteria: A. HWT may be considered on a trial basis if other noninvasive, conservative modalities for the treatment of chronic pain have failed. While medical providers may perform HWT, H-wave devices are also available for home use. Rental would be preferred over purchase during a home trial. Trial periods of more than one month should be justified by documentation submitted for review. B. Although there are no high quality studies to guide recommendations for use, a one-month home-based trial of HWT may be considered following a documented face-to-face clinical evaluation and physical examination performed by the recommending physician, who should also document the following in the medical record: (1) The reason the physician believes that HWT may lead to functional improvement and/or reduction in pain for the patient; & (2) PT, home exercise and medications have not resulted in functional improvement or reduction in pain; (3) The use of TENS for at least a month has not resulted in functional improvement or reduction in pain. C. The one-month initial trial will permit the physician and PT provider to evaluate any effects and benefits. A follow-up evaluation by the physician should take place to document how often the unit was used and any subjective improvement in pain and function. There should be evidence of less reported pain combined with increased functional improvement or medication reduction. D. If treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need for this intervention should be periodically reassessed and documented. The medical records indicate the injured worker failed conservative treatment that included medications, physical therapy; TENs unit; the injured worker is engaged in functional restoration while being treated with the H-wave is medically necessary.