

Case Number:	CM15-0117452		
Date Assigned:	06/25/2015	Date of Injury:	07/27/2011
Decision Date:	07/24/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/18/2015

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 45-year-old female, who sustained an industrial injury on 7/27/11. She reported pain in her right shoulder, low back, right knee and right wrist related to a slip and fall accident. The injured worker was diagnosed as having right shoulder pain, shoulder impingement with AC decompression, lumbago, and sciatica. Treatment to date has included a right shoulder surgery on 2/2/15, physical therapy x 12 sessions with some benefit, Oxycodone, Neurontin and Meloxicam. As of the PR2 dated 5/19/15, the injured worker reports pain in her right shoulder, low back and wrist. Objective findings include right shoulder flexion is 100 degrees, abduction 90 degrees and internal and external rotation 20 degrees. She is also having numbness in the right and left hand. The treating physician requested an H-wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, H-Wave Stimulation, pages 115-118.

Decision rationale: Per guidelines, H-wave 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS), not identified here. Submitted reports have not demonstrated having met these criteria without any report of therapy or participation in an independent home exercise program. 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, not specified in this case. The H-wave is not medically necessary and appropriate.