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| Case Number: | CM13-0004250 | | |
| Date Assigned: | 07/02/2014 | Date of Injury: | 01/02/2013 |
| Decision Date: | 07/30/2014 | UR Denial Date: | 07/18/2013 |
| Priority: | Standard | Application Received: | 07/29/2013 |

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 58 year old employee with date of injury of 1/2/2013. The medical records indicate the patient is undergoing treatment for left shoulder strain/joint pain, rotator cuff NOS, and loc prim osteoarthritis shoulder. The subjective complaints include significant pain at night, neck pain and numbness involving her 4 fingers but deny stiffness. She complains of constant left shoulder pain with distal radiation. The objective findings include neck tenderness along the midline or bilateral paraspinal regions, range of motion is painful and mildly limited; Spurling's is negative although it caused local pain in both directions. No atrophy and no swelling. A positive Hawkins, Neer's, sensation is intact but noted to be decreased in axillary. The treatment has consisted of, recommended activity modification, rest, Tylenol, Vicodin, Ibuprofen, rotator cuff strengthening exercise and cortisone injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE DEVICE FOR THE LEFT SHOULDER PER RX DATED 5/10/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, H-WAVE STIMULATION (HWT),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation, page 117 Page(s): 117.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, H-Wave stimulation (HWT) 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 (TENS). The one-month HWT trial may 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. Rental would be preferred over purchase during this trial. Trial periods of more than one month should be justified by documentation submitted for review. The treating physician has not provided documentation to meet the above criteria for an H-Wave stimulator. Thus, the MTUS does not support the use of H-Wave device. As such, the request for H-Wave device for the left shoulder per RX dated 5/10/2013 is not medically necessary.