MAXIMUS Federal Services

Case Number:	CM13-0007538		
Date Assigned:	03/21/2014	Date of Injury:	08/10/2011
Decision Date:	04/22/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/05/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in California. 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 male sustained an injury on 8/10/11 while employed by [redacted]. Request under consideration include a HOME H-WAVE DEVICE, PURCHASE. Initial injury was reported as right upper extremity pain from cutting a plant overhead. Diagnosis was right deltoid bursitis with treatment plan for ice and gentle ROM. MRI fo the right shoulder dated 11/28/11 revealed chronic supraspinatus tendinopathy with partial thickness bursal surface tear; distal subscapularis tendinopathy without tear; Type III acromion process without evidence of impingement; mild degenerative arthritis of the AC joint. On 4/18/12, the patient underwent right shoulder rotator cuff repair with acromioplasty, debridement of AC joint and injection. Orthopedic QME report of 4/30/13 noted the patient had undergone shoulder surgery with 24 sessions of post-operatie PT with still marked symptoms and poor motion and is Permanent & Stationary with recommendation for follow-up, prescriptions of anti-inflammatory and analgesics for flare-ups, short courses of PT and surgery is unlikely possible. Report of 7/3/13 noted complaints of pain and impaired ADLs. The patient feels better when he uses the H-wave device; howver, pain subsequently returns and is not able to decrease or eliminate the need for medications and continues to use them daily rated at 7/10 pain scale with 25% short-term improvement. Request for the above H-wave purchase was non-certified on 7/15/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME H-WAVE DEVICE, PURCHASE: 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 Page(s): 115-118.

Decision rationale: The Expert Reviewer's decision rationale: This male sustained an injury on 8/10/11 while employed by [redacted]. Request under consideration include a HOME H-WAVE DEVICE, PURCHASE. Initial injury was reported as right upper extremity pain from cutting a plant overhead. Diagnosis was right deltoid bursitis with treatment plan for ice and gentle ROM. Subsequently on 4/18/12, the patient underwent right shoulder rotator cuff repair with acromioplasty, debridement of AC joint and injection. Orthopedic QME report of 4/30/13 noted the patient had undergone shoulder surgery with 24 sessions of post-operatie PT with still marked symptoms and poor motion and is Permanent & Stationary with recommendation for follow-up, prescriptions of anti-inflammatory and analgesics for flare-ups, short courses of PT and surgery is unlikely possible. Report of 7/3/13 noted complaints of pain and impaired ADLs. The patient feels better when he uses the H-wave device; howver, pain subsequently returns and is not able to decrease or eliminate the need for medications and continues to use them daily rated at 7/10 pain scale with 25% short-term improvement. Submitted reports have not provided any specific decreasing dose of medications or increase in ADLs as a result of the H-wave unit trial. There is no change in work status or functional improvement demonstrated to support for the purchase of this unit. 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. The patient has had an H-wave trial use without any documented consistent pain relief in terms of decreasing medication dosing and clear specific objective functional improvement in ADLs have not been demonstrated. There is also no documented failed trial of TENS unit nor any indication the patient has a home exercise program for adjunctive exercise towards a functional restoration approach per submitted report by the provider. The HOME H-WAVE DEVICE, PURCHASE is not medically necessary and appropriate.