

<b>Case Number:</b>	CM13-0017980		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	05/06/2011
<b>Decision Date:</b>	04/28/2014	<b>UR Denial Date:</b>	08/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### 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 Physical Medicine and 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:

The patient is a 58-year-old female who was injured on 05/06/2011. The mechanism of injury is unknown. The prior treatment history has included therapy, TENS unit, and acupuncture. The patient received the H-Wave, and uses it for 30 minutes three times a day. It has controlled the muscular/burning pain in the right shoulder and the right elbow. The medications include: Tramadol 50 mg, Pennsaid 1.5% Solution, Lidocaine 5% patch, Loratadine 10 mg, Xopenex 45 mcg, Patanase 0.6% Nasal Spray, Veramyst 27.5 mcg, Advil, VSL #3 Packet 450 Billion Cell, Amlodipine Besylate 5 mg, Hydrochlorothiazide 25 mg, Linzess 145 mcg, Potassium CL ER 20 mEq, Amitiza Lubiprostone 8 mg, Losartan Potassium 25 mg, and Escitalopram 10 mg. The diagnostic studies reviewed include: An MRI of the lumbar spine without contrast, dated 05/03/2011 with the following impression: 1) L4-L5 disc desiccation; 2) L5-S1 degenerative disc disease with anterolisthesis but no significant canal or exit foraminal encroachment; and 3) The interspinous irregularities at the L4-5 level. These might be associated with pain. An MRI of the right shoulder, dated 06/21/2011, with the following impression: 1) Type II acromion with minimal degenerative change at the acromioclavicular joint. There is no impingement; 2) Tendinopathy of the supraspinatus. Full-thickness tear of the anterior supraspinatus tendon with intertendinous signal changes at the musculotendinous level of the infraspinatus tendon with tendinopathy of the remaining fibers of the infraspinatus tendon; 3) There is tendinopathy of the interarticular portion of the long head of the biceps and apparent tear of the proximal intertubercular sulcus portion of the tendon; and 4) Degeneration/tear of the superior portion of the labrum. An MRI of left shoulder, dated 06/21/2011, with the following impression: 1) Type II acromion with minimal degenerative change of the acromioclavicular joint. There is no impingement; 2) Tendinopathy of the supraspinatus tendon with a small full thickness tear of the tendon at its anterior insertion site; 3) Minor increased T2 signal changes are noted within the

infraspinatus tendon at its tuberosity insertion site possibly representing small partial tears; 4) Tendinopathy of the intrarticular portion of the long head of the biceps; 5) Suspect small tear at the base of the superior labrum; and 6) Nonspecific extensive cystic changes of the glenoid extending to the glenoid articular margin at the labral level posteriorly. The posterior labrum, however, appears intact. There are minor cystic changes of the humeral head at the supraspinatus tendon insertion site and level of partial tear. An MRI right shoulder following arthrogram, with the following impression: 1) Undersurface re-tear, partial tear of the supraspinatus tendon with delamination. The area of tearing measures 15 x 9 mm and involves greater than 50% of tendon thickness; 2) SLAP tear with posterior superior labral extension. There is a deep chondral fissure of the superior glenoid; 3) Glenohumeral synovitis; and 4) Long head biceps tendinosis and fraying. An x-ray of right shoulder arthrogram injection (Pre-MARI), dated 02/13/2013 indicated normal pre MRI arthrogram injection. A progress note dated 09/18/2013, documented the patient to have unchanged pain levels since last visit. The objective findings on exam included that the patient has slowed gait and does not use assistive devices. An examination of the cervical spine revealed no limitation in range of motion. On examination of the paravertebral muscles, tenderness is noted on both sides. No spinal process tenderness is noted. The Spurling's maneuver produces no pain in the neck musculature or radicular symptoms in the arm. All of the upper limb reflexes are equal and symmetric. There were no signs of meningism. An examination of the lumbar spine reveals that the range of motion is restricted with flexion, limited to 40 degrees and the left lateral bending is limited to 1

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**THIRTY (3) DAY TRIAL OF H-WAVE FOR HOME USE QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Durable Medical Equipment, H-Wave Stimulation (HWT), P.

**Decision rationale:** The Chronic Pain Guidelines indicate that H-wave stimulation is not recommended as an isolated treatment intervention, and is only considered for use as a one (1) month home-based trial as part of a comprehensive functional restoration program for the treatment of soft-tissue inflammation. Furthermore, it is only to be considered for use after other conservative treatment options have failed. The current medical records do not indicate that the patient has failed conservative treatment, nor are there any records indicating how the equipment will be used as part of a functional restoration program. Based on the lack of supporting documentation and the lack of evidence to support its use, the request is non-certified.