

<b>Case Number:</b>	CM13-0036736		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	12/04/2008
<b>Decision Date:</b>	02/19/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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 67-year-old female who reported an injury on 12/04/2008. The mechanism of injury was not provided for review. However, this injury resulted in a right shoulder injury, which ultimately resulted in shoulder arthroscopy and labral debridement and mini open rotator cuff repair. The patient had persistent right shoulder pain that failed to respond to postsurgical management to include physical therapy, a TENS unit, medications, and a home exercise program. The patient was prescribed an H-Wave therapy unit. The patient's most recent clinical examination findings included restricted range of motion of the right shoulder secondary to pain, atrophy in the supraspinatus and infraspinatus fossa, and decreased motor strength of the right shoulder girdle described as 4+/5. The patient's diagnoses include right shoulder adhesive capsulitis, current rotator cuff tear status post repair, and right shoulder biceps tenodesis. The patient's treatment plan included continuation of an H-Wave therapy unit usage and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home H-wave device additional 3 month rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, Title 8.

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

**Decision rationale:** The requested Home H-wave device additional 3 month rental is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously used this type of equipment. However, the clinical documentation submitted for review did not provide documentation to support significant functional gains as a result of prior therapy. There was no objective data provided to support continued use. As such, the requested Home H-wave device additional 3 month rental is not medically necessary or appropriate.