

Case Number:	CM13-0047014		
Date Assigned:	12/27/2013	Date of Injury:	08/09/2011
Decision Date:	05/15/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/04/2013

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 Occupational Medicine, has a subspecialty in Interventional Spine, 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 48-year-old male with date of injury of 08/09/2011. The listed diagnoses per [REDACTED] dated 03/14/2013 are: 1. Rotator cuff tear, right shoulder. 2. Acromioclavicular joint arthritis, right shoulder. 3. Impingement syndrome, right shoulder. 4. Subacromial bursitis, right shoulder. 5. Bicipital tendinitis, right shoulder. 6. Status post rotator cuff repair, 03/14/2013. 7. Status post diagnostic arthroscopy, acromioplasty, and debridement of partial-thickness rotator cuff tear, 07/30/2012. According to the report, the patient is 25 weeks post open rotator cuff repair and biceps decompression. He has been in physical therapy and has not worked since 03/15/2013. He says he has improved since his last visit. The objective findings show abduction is 160 degrees, flexion is 140 degrees, internal rotation is 70 degrees, and external rotation is 70 degrees of the shoulder. There is a 5-/5 resisted abduction. Speed's test is 5-/5. The treater is requesting a purchase of an H-wave device.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-WAVE DEVICE; PURCHASE/INDEFINITE USE: Overturned

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 H-WAVE STIMULATION (HWT) Page(s): 117-118.

Decision rationale: This patient presents with chronic shoulder pain. Treater is requesting an H-wave purchase. Review of the reports show a patient compliance and outcome form which noted only 50% improvement. The progress report dated 10/07/2013 by [REDACTED] states that, "The patient has reported a decrease in the need for all medications due to the use of the H-wave device. The patient has reported the ability to perform more activity and greater overall function due to the use of the H-wave device." When addressing H-wave units, MTUS Guidelines, page 117 and 118, supports a one-month home-based trial of H-wave treatment 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 TENS. In this case, the patient has tried and failed TENS unit in the past and reports a decrease in oral medications due to H-wave use. Furthermore, the treater also reports that the patient is permanent and stationary and has returned to work on full duty. Recommendation is for authorization.