

Case Number:	CM14-0006736		
Date Assigned:	02/07/2014	Date of Injury:	01/17/2008
Decision Date:	07/11/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/17/2014

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, 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 55-year-old who has submitted a claim for bilateral shoulder sprain/strain/bursitis/tendinitis, bilateral elbow medial/lateral epicondylitis, bilateral forearm tendinitis, and bilateral wrist sprain/strain associated with an industrial injury date of January 17, 2008. Medical records from 2013 were reviewed. Most of them were handwritten and illegible. The patient complained of bilateral shoulder pain, right more than the left. There was associated weakness and limited mobility over both shoulders particularly with pushing, pulling and reaching. There was reported numbness, tingling and weakness in her hands. Physical examination showed tenderness over the bilateral shoulder with crepitus. Range of motion was limited. Ultrasound of the bilateral shoulder, dated August 22, 2013, showed bilateral rotator cuff tendinosis (supraspinatus), bilateral normal long head biceps tendon (stable in bicipital groove), bilateral normal glenoid labrum, and bilateral normal acromioclavicular joint. MRI of the cervical spine dated December 28, 2008 revealed discogenic changes, C5-C6 and C6-7, 1-2 mm posterior disc bulges in an otherwise normal study. Official report of the MRI was not available. Treatment to date has included medications, physical therapy, acupuncture, psychotherapy, home exercise program, activity modification, and TENS (treanscutaneous electrical nerve stimulation). Utilization review, dated January 2, 2014, denied the request for a home EMS unit because there is no evidence to support its use in chronic pain. The request for H-wave unit rental 30 days was denied as well because it is not recommended as an isolated intervention, but a one month home based trial may be considered as a noninvasive conservative option for diabetic neuropathic pain, or chronic soft tissue inflammation.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME EMS (ELECTROMUSCULAR STIMULATOR) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES (neuromuscular electrical stimulation) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES Devices) Page(s): 121.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulation (NMES) devices are not recommended and are used primarily as part of a rehabilitation program following stroke. Guidelines also state that there is no evidence to support its use in chronic pain. In this case, the patient had shoulder pain since 2010. Most of the recent medical records were handwritten and illegible. There was no discussion regarding the indication for use of NMES device despite it not being recommended by the guidelines. There was also no documentation that the patient previously had stroke requiring its use. The request for a home EMS unit is not medically necessary or appropriate.

H-WAVE UNIT RENTAL FOR THIRTY DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT) Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation Page(s): 117-118.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, H-wave therapy 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 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 transcutaneous electrical nerve stimulation (TENS). In this case, it was not known whether the patient previously used H-wave. Recent medical records were handwritten and illegible. There was documented failure of TENS in December 2013. However, there was no evidence of failure from conservative care, including exercise and medication use. Furthermore, there was no evidence that the patient was still continuing self-exercises at home which is the recommendation as an adjunct to H-wave treatment. There is no documentation of a short-term and long-term treatment plan from the physician. The request for an H-Wave unit rental for thirty days is not medically necessary or appropriate.