

Case Number:	CM14-0104849		
Date Assigned:	07/30/2014	Date of Injury:	06/04/2013
Decision Date:	09/19/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/08/2014

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 Physical Medicine & 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 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 injured worker is a 64 year old male with a reported date of injury of 06/04/2013. The mechanism of injury was not documented. The diagnoses included right rotator cuff tear and right biceps tendon tear. The past treatment included pain medication, physical therapy, and surgery. The MRI dated 08/04/2013 revealed severe supraspinatus tendinosis and partial tearing of the subscapularis insertion. The injured worker underwent right shoulder arthroscopic rotator cuff repair on 10/11/2013. The subjective complaints were right shoulder pain. The physical examination revealed range of motion to the right shoulder was flexion 90 degrees, extension 20 degrees, abduction 70 degrees, adduction 25 degrees, and external rotation 40 degrees. The medications included Anaprox DS 550 mg two times a day, Norco 10/325mg every 6 hours, and Prilosec 20mg daily. The plan was to continue medications. The rationale and the request for authorization form were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) Home Interferential Unit (EMS, H-Wave Unit): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT); Neuromuscular Electrical Stimulation (NMES); Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy, H-wave stimulation (HWT) Page(s): 117-118.

Decision rationale: The request for one (1) home interferential unit (EMS,H-wave unit) is not medically necessary. The California MTUS Guidelines recommend H-wave unit if used as an adjunct to a program of evidence-based functional restoration, following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). The injured worker was noted to be participating in a home exercise program and had tried medications and physical therapy, however no response to the medication or physical therapy was documented in the clinicals received. Additionally there was no documentation that the injured worker tried and failed a TENS unit. As such, the request is not medically necessary.