

<b>Case Number:</b>	CM14-0017340		
<b>Date Assigned:</b>	04/14/2014	<b>Date of Injury:</b>	09/10/2010
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/11/2014

### 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 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 injured worker is a 54-year-old male who reported an injury on 09/09/2010. The mechanism of injury was not specifically stated. Current diagnoses are myalgia and myositis unspecified. The injured worker was evaluated on 01/13/2014. The injured worker reported chronic pain on the right side of the neck and shoulder. The injured worker has participated in 6 sessions of physical therapy. Physical examination revealed limited right shoulder range of motion, mild deltoid atrophy, positive crepitus with range of motion, positive tenderness over the AC joint, mildly positive impingement sign, and mild winging of the scapula. Treatment recommendations included additional physical therapy, massage therapy, and an H-wave unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MASSAGE THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY Page(s): 474.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** California MTUS Guidelines state massage therapy is recommended as an option. Treatment should be an adjunct to other recommended treatment and should be limited to

4 to 6 visits in most cases. There was no specific body part listed in the current request. There is also no quantity listed in the current request. As such, the request is non-certified.

**6 SESSIONS OF PHYSICAL THERAPY TO THE RIGHT SHOULDER AND NECK:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY Page(s): 474.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The injured worker has participated in approximately 6 sessions of physical therapy to date. However, there was no documentation of the previous course of treatment. Therefore, additional therapy cannot be determined as medically appropriate. There was also no physical examination of the cervical spine provided for review. Therefore, the request is non-certified.

**H WAVE UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial may be considered as a non-invasive conservative option. H-wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following a failure of initially recommended conservative care. As per the documentation submitted, there is no evidence of a failure to respond to physical therapy, medications, and TENS therapy. There is also no documentation of a treatment plan including the specific short and long term goals of treatment with the unit. There is no total duration of treatment listed in the current request. Therefore, the request is not medically appropriate. As such, the request is non-certified.