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| Case Number: | CM14-0180194 | | |
| Date Assigned: | 11/04/2014 | Date of Injury: | 05/10/2011 |
| Decision Date: | 12/10/2014 | UR Denial Date: | 10/21/2014 |
| Priority: | Standard | Application Received: | 10/30/2014 |

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, has a subspecialty in Pain Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a work injury occurring on 05/10/11 and continues to be treated for right shoulder pain. She underwent an open rotator cuff repair and, on 03/20/14, an arthroscopic rotator cuff decompression and repair was performed with lysis of adhesions and manipulation. She was seen by the requesting provider on 06/18/14. Her shoulder symptoms were improving with increased range of motion and decreased pain. She had not returned to work. She was having low back pain occasionally radiating into the right lower extremity and occasional numbness and tingling of the third and fourth fingers. Work restrictions had not been accommodated. Physical examination findings included decreased shoulder range of motion and decreased lumbar spine range of motion. The assessment references having completed 12 physical therapy sessions since surgery. Additional physical therapy three times per week for six weeks was requested. On 08/05/14 she was having shoulder and low back pain. Physical therapy was helping with strengthening and range of motion. She was performing a daily home exercise program. She was using an H-wave unit every other day two times per day at night for 30 minutes. Physical examination findings included decreased lumbar spine range of motion with lumbar spine tenderness. Straight leg raising was negative.

IMR ISSUES, DECISIONS AND RATIONALES

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

The lease or rental of an H-Wave unit, electrodes (per pair), and conductive paste or gel:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

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

Decision rationale: The claimant is more than 3 years status post work-related injury and continues to be treated for chronic right shoulder and low back pain. Although H-wave stimulation is not recommended as an isolated intervention, a one-month home-based trial of may be considered as a noninvasive conservative option for the treatment of chronic pain. H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as transcutaneous electrical nerve stimulation (TENS), in terms of its waveform. During the trial it should be documented as to how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, the claimant was performing a daily home exercise program and using an H-wave unit every other day two times per day at night for 30 minutes with benefit. Therefore, the requested H-wave unit was medically necessary.