

Case Number:	CM14-0027879		
Date Assigned:	06/16/2014	Date of Injury:	05/12/2011
Decision Date:	07/18/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/05/2014

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:

She is a 48 year old female who was injured on 05/12/2011. She sustained an injury to her left shoulder. Prior medication history included Motrin and Lidoderm. Prior treatment history has included physical therapy. Diagnostic studies reviewed include MRI of the left shoulder dated 12/13/2013 revealed: 1) There is extensive partial tears and longitudinal split tears involving the infraspinatus and to a lesser extent, the supraspinatus tendons; 2) There is a partial tear of the superior fiber of the subscapularis tendon; 3) There is extensive partial tear and fraying of the intra-articular long head biceps tendon with at least partial avulsion from the biceps tendon anchor at the superior glenoid labrum; and 4) Widened left AC joint consistent with a prior left AC joint separation. Progress report dated 02/13/2014 states the patient complained of pain, impaired range of motion and impaired activities of daily living. There is no exam for review. Prior utilization review dated 02/13/2014 states the request for a H-wave device purchase is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: H-WAVE DEVICE (PURCHASE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) H-Wave Stimulation (HWT).

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

Decision rationale: The CA MTUS guidelines recommend there are no published studies to support the use of H-wave unit unless as an isolated intervention. The guidelines further indicate, "the one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function." The patient had a trial of H-Wave and TENS unit with a statement indicating decrease in medications for pain; however, there is no documentation of objective functional improvement. Based on the CA MTUS guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.