

Case Number:	CM14-0061784		
Date Assigned:	07/09/2014	Date of Injury:	03/12/2012
Decision Date:	12/17/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/03/2014

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 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:

A physical therapy progress report dated March 26, 2014 indicates that the patient has undergone 14 sessions of physical therapy including electrical stimulation. An operative report dated February 4, 2014 indicates that the patient underwent an arthroscopic rotator cuff repair. A letter dated October 29, 2013 appears to be a bill for an H-wave unit. A progress report dated October 9, 2013 identifies subjective complaints of left shoulder pain now 22 weeks following arthroscopic surgery. He has been using physical therapy and a home exercise program. Physical examination revealed restricted shoulder range of motion. Diagnoses include status post left shoulder arthroscopic surgery and post-surgical adhesive capsulitis. The treatment plan recommends continuing a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave Unit Device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulator Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114, 117-118.

Decision rationale: Regarding the request for H-wave unit, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-wave stimulation 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 diabetic neuropathic pain, or 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation there is not indication that the patient has undergone a 30 day tens unit trial as recommended by guidelines. There is no statement indicating how frequently the tens unit was used, and what the outcome of that tens unit trial was for this specific patient. Furthermore, there is no documentation that the patient has undergone an H-wave trial. In the absence of such documentation, the currently requested H wave device is not medically necessary.