

Case Number:	CM14-0064007		
Date Assigned:	06/23/2014	Date of Injury:	11/06/2007
Decision Date:	07/25/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/21/2014

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 Internal 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:

Patient is an injured worker with a right shoulder condition. Date of injury was 11-06-2007. Office visit note dated 2/19/2014 by [REDACTED] provided a progress report. History of present illness: The patient is status post right shoulder arthroscopy and correction on 12/11/12. The patient has continued to experience right shoulder pain. On 11/5/13, we obtained a right shoulder MRI which demonstrated a possible full-thickness tear of the supraspinatus. She has since been attending formal physical therapy which has helped considerably. Most bothersome to her is her right anterior shoulder pain. She is concerned about her ability to return to work due to this weakness. She continues her at home exercise program. She also continues to take over-the-counter Aleve once in the morning. Physical examination: The right shoulder demonstrates 160 active forward flexion, 150 active abduction. There is a 10 internal rotation contracture. Positive Yergason's test. Rotator cuff testing is 5/5 except for supraspinatus which is 4/5. Imaging studies: MRI gadolinium arthrogram right shoulder 11/5/13 demonstrates distal supraspinatus tendinosis and articular surface partial-thickness tear supraspinatus tendon with a possible full-thickness tear. Distal infraspinatus tendinosis with partial thickness intrasubstance tear. Subscapularis tendinosis. Evidence of previous subacromial decompression. Long head of biceps tendon and its anchor appear within normal limits. Impression: Status post right shoulder arthroscopy correction on 12/11/12 with persisting pain, examination evidence of right bicipital tendinitis and MRI findings of a possible full thickness supraspinatus tear; Rotator cuff sprain and strain; Bicipital tenosynovitis. Plan: 1. Right shoulder MRI performed on 11/5/13 demonstrated a possible full-thickness tear of the supraspinatus. Fortunately, she has improved significantly with physical therapy. She appears to have a right bicipital tendinitis. 2. We would like for her to continue formal physical therapy, specifically with iontophoresis and cross friction ice massage to the right anterior shoulder. She will also perform cross friction ice massage at

home. We will also look into obtaining a TENS (Transcutaneous Electric Nerve Stimulation) unit for home use. 3. She takes an occasional over-the-counter Aleve. 4. She remains off work from her usual occupation as an ultrasound tech to her shoulder disability. 5. She will return to the office in 6 weeks. If at that time she has not improved, we will consider providing a right shoulder Kenalog/Marcaine injection to the bicipital groove. Utilization review dated 03-06-2014 recommended non-certification of the request H-wave device. RFA was dated 02-26-2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-wave device (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117, 45, 49. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic), Electrical stimulation.

Decision rationale: Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines states that H-wave stimulation (HWT) may be considered - if used as an adjunct to a program of evidence-based functional restoration, and only following failure of conservative care, including recommended physical therapy, plus transcutaneous electrical nerve stimulation (TENS). Office visit note dated 2/19/2014 documented that there was not a failure of physical therapy - "She has improved significantly with physical therapy." In the office visit note, the physician documented - "We will also look into obtaining a TENS unit for home use" - indicating that the patient has not failed trial TENS. There is no documentation of failure of transcutaneous electrical nerve stimulation (TENS). MTUS guidelines requires enrollment in a functional restoration program for patient considering H-wave trial. There is no documentation of enrollment in functional restoration program. Review of medical records demonstrates that the patient does not satisfy the selection criteria for H-wave trial. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints (Page 203) states: Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) states: Electrical stimulation is not recommended. There was a lack of evidence regarding efficacy. The 3rd edition of the ACOEM Occupational medicine practice guidelines: Evaluation and management of common health problems and functional recovery in workers (2011) Table 2 Summary of Recommendations for Managing Shoulder Disorders addresses H-wave stimulation. For shoulder disorders, H-wave stimulation is not recommended. Clinical guidelines and medical records do not support the medical necessity of H-wave stimulation device. Therefore, the request for H-wave device (rental or purchase) is not medically necessary and appropriate.