

Case Number:	CM14-0129202		
Date Assigned:	08/18/2014	Date of Injury:	06/28/2013
Decision Date:	02/11/2015	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/13/2014

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:

Patient is a 60 year-old male with date of injury 06/28/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/11/2014, lists subjective complaints as pain in the left shoulder. Objective findings: Examination of the left shoulder revealed full active assist range of motion. Positive Neer's and Hawkin's signs. Tenderness was noted about the acromioclavicular joint and cross body adduction. Lateral elbow pain with handshake test. Resisted wrist extension on the left side caused lateral elbow pain. Diagnosis: 1. Left shoulder impingement syndrome with acromial clavicular joint arthrosis, and possible intra-articular injury, based on mechanism 2. Left elbow lateral epicondylitis 3. Lumbosacral strain/arthrosis. Patient has currently utilized an H-wave trial and notes a 50% reduction in symptoms as well as improvement in function. Provider notes the patient has failed with physical therapy, TENs and medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave Device: Overturned

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): 117-118.

Decision rationale: The MTUS does not recommended H-wave stimulators as an isolated intervention. There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects; however, the patient has been treated with a TENS unit without improvement and has recently undergone a one-month HWT trial where the provider reports that the patient has had at least 50% improvement in pain. I am reversing the previous utilization review decision. H-Wave Device is medically necessary.