

Case Number:	CM15-0185773		
Date Assigned:	09/25/2015	Date of Injury:	10/24/2014
Decision Date:	11/06/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 injured worker is a 49 year old male who sustained an industrial injury on 10/24/2014. A MRI 12/02/2014 revealed complete tears of the supraspinatus and infraspinatus tendons and a tear of the biceps tendon. Medical records indicated the worker was treated for a torn biceps, torn rotator cuff, and impingement syndrome left shoulder and lumbar spine sprain-strain. A left shoulder arthroscopy with rotator cuff repair, subacromial decompression and biceps tenodesis was done 03-19-2015. The worker had 18 post-op physical therapy visits. In the provider visit of 07-27-2015, the worker states the shoulder is improved with improved range of motion and less discomfort. He is attending physical therapy, doing home exercises, and taking occasional Advil. On physical exam, the left shoulder demonstrates active abduction to 130 degrees and active forward flexion to 140 degrees. External rotation is 80 degrees and internal rotation is to L1. The plan is to request additional therapy for improving range of motion and strength. The worker is currently not working. A request for authorization was submitted 08-11-2015 for One (1) home h-wave device and 6 sessions of physical therapy. A utilization review decision 08/21/2015 non-certified the request for One (1) home h-wave device and certified the request for 6 sessions of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) home h-wave device: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: One (1) home H-wave device is not medically necessary. Per MTUS, H-wave "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain." The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As it relates to this case H-wave was recommended as solo therapy for pain associated with the shoulders. Per MTUS and the previously cited medical literature H-wave therapy is not medically necessary as solo therapy and her current diagnoses.