

Case Number:	CM15-0024470		
Date Assigned:	02/17/2015	Date of Injury:	04/16/2014
Decision Date:	03/30/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/09/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 61 year old male who sustained an industrial injury on 4/16/14 when he lifted a heavy object and felt immediate pain in his right shoulder. Currently he is experiencing burning pain in the right shoulder that radiates to the upper arm with numbness/ tingling to the right hand. In addition he has insomnia. He indicates his pain intensity to be 4-5/10. His activities of daily living are compromised. Medications specific to the complaint include Tramadol, Terocin cream. Diagnoses are status post right shoulder surgery (right shoulder arthroscopy (7/17/14) with significant loss of range of motion of the right shoulder, as well as significant loss of power in the right shoulder girdle; diabetes. Treatments to date included physical therapy with some relief; home transcutaneous electrical nerve stimulator unit. Diagnostics included abnormal MRI of the right shoulder (6/14); radiographs of the right shoulder (10/17/14) show mild anterior cruciate joint hypertrophy and suture anchor; abnormal electromyography and nerve conduction studies. In the progress note dated 1/5/15 the treating provider requests purchase of home H-wave device for the right shoulder to reduce or eliminate pain, to improve functional capacity and activities of daily living, to improve circulation and decrease congestion in the injured region and to provide a self-management tool to the injured worker. On 1/19/15 Utilization Review non-certified the request for the purchase of a home H-wave device for the right shoulder citing MTUS: Chronic Pain Medical Treatment Guidelines: transcutaneous electrotherapy: H-wave stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Home H-wave device for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT), p117 Page(s): 117.

Decision rationale: The claimant is nearly one year status post work-related injury and continues to be treated for radiating right shoulder pain. He has a TENS unit for home use which he continues to use. Although H-wave stimulation is not recommended as an isolated intervention, guidelines recommend that a one-month home-based trial may be considered as a noninvasive conservative option. In this case, the claimant has not undergone a trial of H-wave stimulation and is already using home based TENS with benefit. Therefore purchase of an H-wave unit is not medically necessary.