MAXIMUS Federal Services

Case Number:	CM14-0149071		
Date Assigned:	09/18/2014	Date of Injury:	08/22/2013
Decision Date:	10/17/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/14/2014

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 Orthopaedic Surgery 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:

This 59-year-old male sustained an industrial injury on 8/22/13. Injury occurred when a hydraulic carriage, weighing about 50 pounds, began to slip off a cart and he twisted to grab it. Injuries were reported to the left shoulder and low back, and records indicated a diagnosis of bilateral carpal tunnel syndrome. The 12/9/13 left shoulder MRI impression documented a partial tear of the infraspinatus tendon at the musculotendinous junction and supraspinatus tendinopathy, There was no evidence of full thickness cuff tear or tendon retraction. There was acromioclavicular degenerative joint disease and subacromial/subdeltoid fluid suggesting bursitis. The patient underwent left shoulder arthroscopy, acromioplasty, distal clavicle excision, and joint debridement on 4/14/14. The 4/23/14 initial occupational therapy evaluation cited long-standing left upper extremity pain that had improved since surgery. Shoulder range of motion testing documented flexion 155, abduction 155, internal rotation 60, and external rotation 75 degrees. Over the course of care, the patient was treated with interferential current therapy. The 5/15/14 H-wave patient compliance and outcome report documented 106 days of use. Outcome measures indicated the patient was able to sleep better and increase daily activity. Pain was rated 6.5/10 with a 35% improvement reported following H-wave use. The H-wave forms indicated that the patient had tried medications and 12 visits of physical therapy in the past. TENS unit had been tried without adequate relief/benefit. The 6/20/14 treating physician report indicated the patient had mild residual left shoulder discomfort. Physical exam documented full left shoulder range of motion with good strength. The treatment plan recommended completion of therapy and follow-up in 6 weeks. The 9/10/14 utilization review denied the 9/2/14 request for home H-wave device purchase as there was no indication of a measurable reduction in medication dosage, quantity and frequency of pain medications following the use of H-wave. There was no sustained

reduction in pain scores and limited evidence to suggest a change in work status with use of the H-wave.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home H-wave device purchase: Upheld

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

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

Decision rationale: The California MTUS guidelines do not recommend H-wave stimulation as an isolated intervention. A one-month home based H-wave trial may be considered as option for diabetic neuropathy 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 (i.e. exercise) and medications, plus transcutaneous electrical stimulation (TENS). Guidelines define functional improvement as either a clinically significant improvement in activities of daily living or a reduction in work restrictions; and a reduction in the dependency on continued medical treatment. Guideline criteria have not been met. There is no evidence that conservative treatment, including medications and physical therapy, have failed to provide benefit to this patient in the post-operative period. There is no evidence of an objective measurable benefit with the documented H-wave trial consistent with the MTUS definition of functional improvement. Therefore, this request is not medically necessary.