

Case Number:	CM15-0019446		
Date Assigned:	02/09/2015	Date of Injury:	09/01/2010
Decision Date:	03/25/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/03/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 47 year old male, who sustained an industrial injury 9/1/10. He has reported left shoulder injury. The diagnoses have included ankle strain, Achilles tendon sprain, shoulder strain, shoulder impingement and frozen shoulder. Treatment to date has included oral medications, cubital nerve release surgery and left shoulder rotator cuff repair. Currently, the injured worker complains of ongoing pain in left shoulder, lower back, left hand and left ankle with radiation down left arm; he describes it as sharp, stabbing, burning, aching, dull, throbbing and radiating. On 12/9/15, crepitus of left shoulder with tenderness to palpation in the biceps tendon on the left is noted on exam. Trigger points palpated in the upper trapezius, lower trapezius and splenius capitis bilaterally. Decreased strength and flexion of left shoulder is noted. The oral medication has been helpful and effective for him with frequent breakthroughs of pain. On 1/9/15 Utilization Review non-certified a DME-H Wave Unit, noting the lack of evidence to recommend H Wave Unit and it is not recommended as an isolated intervention for pain. The ODG was cited. On 1/29/15, the injured worker submitted an application for IMR for review of DME-H Wave Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME- H Wave Unit: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: The request is considered medically necessary. According to MTUS guidelines, in order to try an H-wave device, the patient has to have failed conservative therapy such as medications, physical therapy and a trial of a TENS unit. As per the chart, the patient did not have any improvement with physical therapy, home exercise program, acupuncture, medication, and the use of a TENS unit. Therefore, the use of an H-wave device is reasonable and medically necessary at this time.