

Case Number:	CM15-0099534		
Date Assigned:	06/02/2015	Date of Injury:	01/24/2012
Decision Date:	07/07/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	05/22/2015

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: Texas, California
 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:

This is a 56 year old female patient, who sustained an industrial injury on 1/24/12. The diagnoses have included mild impingement syndrome, left shoulder. She sustained the injury while returning file to top self. Per the doctor's note dated 5/5/2015, she has complaints of bilateral shoulder and neck pain. The physical examination revealed neck- tenderness and full range of motion; bilateral shoulders- tenderness, decreased range of motion and evidence of impingement. The medications list includes vicodin, ambien, oxycontin, celebex and motrin. She has undergone right shoulder rotator cuff repair, acromioplasty on 4/16/13. She has had left shoulder X-rays with normal findings. She has had physical therapy and home exercise program for this injury. The request was for one month trial of H-wave unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 month trial of H-wave unit: Upheld

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

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

Decision rationale: Request-1 month trial of H-wave unit Per the CA MTUS Chronic Pain Medical Treatment Guidelines-H-wave stimulation (HWT) is "Not recommended as an isolated intervention, but a one-month home-based trial of H Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain, 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 nerve stimulation (TENS)." Evidence of diabetic neuropathy is not specified in the records provided. Evidence of failure of conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. Previous conservative therapy notes are not specified in the records provided. The medical necessity of 1 month trial of H-wave unit is not fully established for this patient at this juncture.