

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/17/2013

[REDACTED]

[REDACTED]

|                           |              |
|---------------------------|--------------|
| Employee:                 | [REDACTED]   |
| Claim Number:             | [REDACTED]   |
| Date of UR Decision:      | 5/24/2013    |
| Date of Injury:           | 2/6/2013     |
| IMR Application Received: | 6/10/2013    |
| MAXIMUS Case Number:      | CM13-0000624 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for H-wave home device for right shoulder /purchase **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for H-wave home device for right shoulder /purchase is not **medically necessary and appropriate**.

### **Medical Qualifications of the Expert Reviewer:**

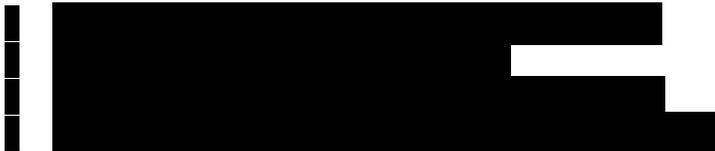
The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic surgery, and is licensed to practice in California. He/she has been in active clinical practice for more 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

37 year old male with date of injury 2/16/13. Patient status post 14 session of physical therapy. MRI right shoulder 4/5/13 demonstrates supraspinatus tendinosis with moderate osteoarthritis acromioclavicular joint. Examination from 5/9/13 demonstrates continued pain and diminished range of motion. Request is for H-wave stimulation.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:



The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Medical Treatment Utilization Schedule- Shoulder Complaints and Chronic Pain Medical Treatment Guidelines- H-wave stimulation, both are a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, H-wave stimulation, pg. 117, which is a part of the MTUS.

Rationale for the Decision:

Per the MTUS guidelines page 117, Chronic pain section, H-wave stimulation, 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 (Julka, 1998) (Kumar, 1997) (Kumar, 1998), 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). A review of the records indicates there is no evidence of diabetic neuropathic pain or chronic soft tissue inflammation in the clinical scenario presented. **The request for the H-wave home device for the right shoulder/purchase, is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.