
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/5/2013
Date of Injury: 8/24/2012
IMR Application Received: 8/19/2013
MAXIMUS Case Number: CM13-0013196

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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.

DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 37-year-old female with date of injury of 08/24/2012. Most recent clinical assessment is from 09/19/2013 with Dr. [REDACTED] where the claimant was with complaints of left shoulder pain, left upper extremity and left arm pain, and GI issues. It states she has been back to work 6 hours per day with continued complaints of right forearm pain, and stating her left shoulder feels better since the previous visit. Current medications are Medrox ointment and ibuprofen. Physical examination finding was "not performed today." The claimant's working diagnoses were (1) bicipital tenosynovitis; (2) rotator cuff injury; and (3) rotator cuff tearing. She was returned back to work on a trial basis, was to continue with a home exercise program, and was to not lift greater than 30 pounds. There is an H-wave device compliance note, stating the H-wave unit was initiated on 04/23/2013 and was used for 51 days with documentation of 80% improvement in the claimant's complaints. It stated other forms of treatment included physical therapy, medication management, and other forms of electrical stimulation. It stated the H-wave device has allowed the claimant to decrease use of medication. Previous surgery to the left shoulder has taken place on 01/29/2013 in the form of arthroscopy, labral debridement, subacromial decompression, and distal clavicle excision. No postoperative imaging is supported for review.

IMR DECISION(S) AND RATIONALE(S)

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

1. H-Wave rental for 3 months is not medically necessary and appropriate.

The Claims Administrator did not cite any guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 117, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on CAMTUS Chronic Pain Guidelines, continued use of an H-wave device would not be supported. The claimant is now 10 months following left shoulder surgical process that included a subacromial decompression, labral debridement, and distal clavicle excision. At last clinical assessment of 09/2013, the claimant was noted to be doing quite well in regards to the shoulder, stating diminished pain-related complaints and treatment plan to include returning to work. While H-wave compliance record states the claimant noticed 80% improvement and diminished use of medications with the device, the claimant's current improvement on examination also fits the timeframe of a healing process from her recent left shoulder surgery. In absence of physical examination findings, there would be no indication for a 3 month continuation of the above device that has already been utilized for greater than 2 months' time. The claimant's symptoms on both subjective complaints as well as returning to function do not support continued use of this stimulation device. Guidelines also would not support the role of the device for greater than 1 month that has already been exceeded. Given the claimant's improvement and frequency of use of the device, a 3 month continuation would not be indicated.

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.



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