

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/19/2013  
Date of Injury: 1/21/2012  
IMR Application Received: 8/23/2013  
MAXIMUS Case Number: CM13-0015590

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 patient was injured in a work related accident on January 21, 2012. The clinical assessment for review is an August 29, 2013 report indicating present complaints of low back pain, bilateral knee pain right greater than left with radiating right lower extremity pain to the foot. The physical examination findings showed restricted lumbar range of motion with diminished right knee motion from 5 degrees to 120 degrees of various deformities, retropatellar crepitation, joint line tenderness and no ligamentous instability. The lumbar examination was with diminished motion, negative straight leg raise and no documentation of neurologic deficit. The working assessment was status post right knee surgery times two to include arthroscopy and debridement, residual knee pain with multi compartment osteoarthritis, low back pain chronic and mechanical in nature without radiculopathy, multilevel degenerative joint disease. At that time there was noted to have been recent use of an H-Wave stimulator device. There is a recommendation for continuation of the device for three additional months beginning August 12, 2013. The previous records indicate a previous trial of a TENS device was attempted during the patient's post operative physical therapy and found to be ineffective creating no objective lasting benefit.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. The request for H-Wave 3 additional months is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, H-wave stimulation (HWT), which is part of MTUS.

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

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Guidelines the continued use of an H-wave device would not be indicated. The H-wave devices are not recommended as an isolated intervention and are only recommended for diabetic neuropathy pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based functional restoration. The records do not support significant diminished pain levels with a trial period of the device. **The request for H-Wave 3 additional months is not medically necessary and appropriate.**

/amm

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.

[REDACTED]  
[REDACTED]  
[REDACTED]

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