

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/31/2013
Date of Injury:	2/12/2011
IMR Application Received:	8/22/2013
MAXIMUS Case Number:	CM13-0015639

- 1) MAXIMUS Federal Services, Inc. has determined the request for **H-wave or IF unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/22/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/9/2013. 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 or IF unit** 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 Physical Medicine and Rehabilitation 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:

The underlying date of injury in this case is 02/12/2011. The treating diagnosis is left rotator cuff impingement. An initial Medical Review of 07/31/2013 recommended non-certification of an H-wave or interferential unit. That review notes that the patient had recently presented with ongoing signs of rotator cuff weakness with the nonspecific change from past evaluations and with MRI imaging of 06/27/2011 having previously demonstrated supraspinatus tendinosis. The prior review concluded that the situation might have evolved into a surgical lesion and that an H-wave or interferential unit would not be indicated and that overall there is no clinical indication presented to support this request.

An MRI of the left shoulder of 08/08/2013 demonstrated supraspinatus tendinosis with a high-grade, partial-thickness tear of the supraspinatus.

Previously on 07/17/2013, orthopedist Dr. [REDACTED] noted that the patient felt that therapy was helping and that the physical therapist had requested an H-wave machine, and therefore Dr. [REDACTED] recommended this further request of the patient's physical therapies. Dr. [REDACTED] also noted great concern regarding rotator cuff weakness, which was a change from prior exam. Therefore, Dr. [REDACTED] recommended an MRI to determine if the patient's partial rotator cuff tear had become a full tear.

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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for H-wave or IF unit :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Section on H-Wave Stimulation page 117, and the Section on Interferential Current Stimulation pages 118-120, which are part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines' Section on H-Wave Stimulation, states that such treatment is "not recommended as an isolated intervention, but a 1-month home-based trial of H-wave stimulation may be considered as a noninvasive conservative option...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 and medications plus transcutaneous electrical nerve stimulation (TENS)." The medical records provided for review do not indicate that this employee has failed initially recommended conservative care. To the contrary, the records indicate that initial conservative care was interrupted by a substantial change in the employee's physical examination prompting a possible change in diagnosis with a potential worsened rotator cuff tear. The treatment guidelines do not support H-wave stimulation as medically necessary in this situation. Regarding interferential stimulation, the Chronic Pain Medical Treatment Guidelines discuss this treatment as "possibly appropriate" in very specific conditions. These conditions include pain ineffectively controlled due to diminished effectiveness of medications, pain ineffectively controlled with medications due to side effects, or pain unresponsive to conservative measures. The medical records do not indicate that this employee meets these criteria either. Overall, the physician notes indicate that the request for an H-wave or interferential unit was based on a physical therapist recommendation. However, it is not clear that the treating physician agreed with that recommendation, since the treating physician instead recommended additional imaging due to a substantial change in the employee's physical exam. For these reasons, the medical records and guidelines do not support the requested treatment. **The request for H-Wave or IF Unit 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, 18th Floor
Oakland, CA 94612

/MCC

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.