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## Independent Medical Review Final Determination Letter

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[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/27/2013

<b>IMR Case Number:</b>	CM13-0018522	<b>Date of Injury:</b>	04/05/2012
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/22/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/29/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] MD		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
DME: H-WAVE UNIT 30 DAY RENTAL/TRIAL, HEEL CUP			

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: OVERTURN. This means we decided that all 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 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 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 underlying date of injury in this case is 04/05/2012. The patient's diagnoses are a bimalleolar fracture and degenerative joint disease. The patient presented with ongoing tenderness of the malleoli and posterior tibial tendon as well as swelling over the anterior surface of the ankle. Medical records indicate this patient continues to perform a home exercise program and stretching and has failed past treatment, including a TENS unit. The patient has been noted on exam to have tenderness over the posterior tibial tendon and mild swelling over the posterior tibial tendon with 4+/5 muscle strength and ankle dorsiflexion and plantar flexion. Requested treatment has included podiatry consultation as well as use of an H-wave unit and heel cup. Prior physician's review indicated there was insufficient evidence for failure of prior conservative care allowing for consideration of an H-wave unit. That prior review also noted that Milliman Care Guidelines recommends the use of an over-the-counter arch support or soft heel pad as an option for plantar fasciitis but not for Achilles tendinitis and noted that those guidelines did not address the current diagnoses of a bimalleolar fracture and degenerative joint disease.

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

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

**1. Thirty (30) day rental of a H-Wave unit is medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, H-Wave Section, page 117, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines Section on H-Wave Stimulation on Page 117 states, *“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...for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration and only after failure of initially recommended conservative care, including recommended physical therapy and medications plus transcutaneous electrical nerve stimulation.”* This employee classically meets these criteria. The employee clearly has soft tissue inflammation status post a complex lower extremity fracture which has failed extensive postsurgical conservative treatment, including TENS use. This employee does specifically meet the criteria for an H-wave unit. The prior review concludes that the did not meet the past requirements for conservative treatment, although the records do outline substantial efforts of gait training after surgery for lower extremity fracture as well as TENS. **The request for a thirty (30) day rental of a H-Wave unit is medically necessary and appropriate.**

## **2. Purchase of a heel cup for the left ankle is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guideines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Ankle and Foot Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 14) page 370, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 14 Ankle, Page 370, recommends under *“methods of symptom control for ankle and foot complaints...plantar fasciitis: heel donut.”* The current request for heel cup semantically appears to be equivalent to the guideline recommendation for a heel donut. Prior physician review appears to focus on the primary diagnosis of a lower extremity fracture, although the medical records clearly outline ongoing signs of inflammation as a secondary diagnosis. The guidelines clearly support the use of a heel cup or heel donut for treatment of plantar fasciitis and the guidelines do not provide a rigid definition of this diagnosis be restrictive in utilizing this equipment. **The request for purchase of a heel cup for the left ankle is medically necessary and appropriate.**

/JR

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]

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