
Independent Medical Review Final Determination Letter

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

Dated: 12/31/2013

IMR Case Number:	CM13-0018549	Date of Injury:	07/05/2007
Claims Number:	[REDACTED]	UR Denial Date:	08/08/2013
Priority:	STANDARD	Application Received:	08/29/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] MD		
Treatment(s) in Dispute Listed on IMR Application:			
PURCHASE OF H WAVE UNIT			

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, has a subspecialty in Reconstructive Surgery and is licensed to practice in Illinois, Texas and Wyoming. 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 is a 45-year-old female who reported an injury on 07/05/2007. The patient is noted to have complaints of low back pain radiating into the bilateral lower extremities. The patient was noted to be initially injured while transferring a patient when she felt a pop in her lower back. The patient was also noted to have an injury to the left hand. The patient is currently being prescribed Norco, Soma, and gabapentin. The patient has current diagnoses of multiple level lumbar disc protrusions and facet hypertrophy. On recent physical examination, the patient had lumbar paraspinal tenderness and muscle spasms with positive bilateral straight leg raise, limited lumbar spine range of motion, 4/5 bilateral EHL motor strength and decreased sensation in the right L5-S1 distribution. The patient's current recommendations include ongoing medication management, epidural steroid injection, drug screen, blood workup and H-wave device.

IMR DECISION(S) AND RATIONALE(S)

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

1. The purchase of an H-wave unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS: pp 117-118, Web Edition.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, H-wave Stimulation, page 118, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS states that H-wave stimulation (HWT) is 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 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). The medical records submitted for review do indicate that the employee has a history of neuropathic pain which has been unresponsive to conservative care. However, the employee is being recommended for a lumbar epidural steroid injection. The results of the proposed epidural steroid injection have not been submitted for review. The documentation provided fails to indicate that the employee has specifically failed recommended conservative care per California MTUS Guidelines including use of a TENS unit. Furthermore, the request for purchase would exceed California MTUS Guideline recommendations for a 1 month home-based trial. **The request for the purchase of an H-wave unit is not medically necessary and appropriate.**

/dso

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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