MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 10/3/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/2/2013
Date of Injury:	11/23/2010
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0001992

1) MAXIMUS Federal Services, Inc. has determined the request for an H-Wave device purchase **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 an H-Wave device purchase **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:
The independent MD who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Preventative Medicine and Occupational Medicine, 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.

Case Summary:
Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013:

"According to progress report dated 4/04/13 by [redacted] MD, the patient came in for evaluation due to chief complaint of right wrist, left shoulder and neck pain at 4/10 level. Oswestry disability test was at 45 percent. Lower back pain radiated to the lower left extremity with numbness and tingling sensation noted. On exam, the patient had decreased range of motion on neck with positive hypertonicity, the patient had back pain with decreased painful range of motion."

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 for Independent Medical Review (received 07/18/2013)
- Utilization Review by [redacted] (dated 07/02/2013)
- Employee Medical Records provided by [redacted]
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for H-Wave device for purchase:**

   Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:
   The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 117-118, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute

the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:
The employee sustained a work-related injury on 11/23/2010, resulting in injury to the employee's lower back, right wrist, left shoulder and neck. Treatments have included analgesic medications, care from providers in various specialties, work restrictions, and an unspecified amount of physical therapy. The request is for an H-Wave Device purchase.

The MTUS Chronic Pain Medical Treatment Guidelines state that H-wave stimulation is not recommended as an isolated intervention, but can be employed on a one-month trial basis in those individuals with chronic soft tissue inflammation who have failed first-line analgesic medications, second-line physical therapy, and a third-line TENS unit. The medical records provided for review do not indicate whether the employee has had a trial of an H-wave home stimulation device. Also, the employee was experiencing side-effects and received no benefits from the E-stim device being used. The request for an H-Wave Device purchase **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/mbg

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.