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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/30/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/22/2013
Date of Injury:	9/19/2011
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005655

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 Pain Management and Rehabilitation, and has a subspecialty in Pain Management 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 had an injury at work on 9/19/11. Diagnoses include Chronic Pain syndrome, cervical disc protrusion, stenosis, lumbar radiculopathy, shoulder pain, knee sprain, hysteria and post-traumatic stress disorder. The patient has total disability. She has been treated in a functional restoration program. An H wave unit has been used. There is concern about the medical necessity of the H wave unit and the continued use of Hydrocodone.

IMR DECISION(S) AND RATIONALE(S)

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

1. Purchase of an H-wave unit is medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS H-wave stimulation (HWT), Section 9792.20 Medical Treatment Utilization Schedule—Definitions (f) "Functional Improvement), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronice Pain Medical Treatment Guidelines H-wave Stimulation Section, Page 117, which is part of the MTUS.

The Physician Reviewer's decision rationale:

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 evidenced-based functional restoration. The H-wave stimulation was used for this purpose and there is evidence of a one month trial to assess benefits. The patient noted the H-wave unit decreased pain and improved walking duration. Based on the patient response to H- wave stimulation, it appears to be medically necessary. **The request for H-wave unit is medically necessary and appropriate.**

2. Hydrocodone/ APAP 10/325 mg #60 is medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS 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, Ongoing Management Section, Pages 78 and 91, which is part of the MTUS.

The Physician Reviewer's decision rationale:

There appears to be adequate monitoring of proper use and justification for continued use of Hydrocodone. Per Opioids section on page 91, the amount of Hydrocodone is within acceptable limits. **The request for Hydrocodone/ APAP 10/325 mg #60 is medically necessary and appropriate.**

/jb

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.

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