

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/6/2013

[REDACTED]

[REDACTED] t

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	6/13/2011
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007020

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

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/5/2013. 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 purchase/indefinite use **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 Oklahoma. 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 patient reported an injury on 06/13/2011. The examination dated 05/28/2013 per [REDACTED], MD revealed the patient has pain on the S1 and L5 distribution on the right. The patient was noted to have radicular pain now moving to the left S1 distribution. The physical examination revealed the patient has spasms, painful and limited range of motion, a positive Lasegue's on the right, positive straight leg raise on the right at 45 degrees, and decreased sensation on the right at the L5 level. The patient was noted to have motor weakness on the right of 4/5 at L5 and S1 distribution. The patient is noted to have pain on the right at the L4 to S1 level. The treatment plan was stated to be an H-wave trial. The objective findings on 07/08/2013 per Dr. [REDACTED] revealed the patient reported the H-wave following observations after an initial treatment of the home H-wave. The patient had a drop in his pain level from 8/10 to 3/10 for a 63% improvement. On a scale of 10, range of motion and/or function improved from 5/10 to 3/10 or 40%. Overall, the patient stated that the range of motion and/or function has increased. The patient has been noted to have tried a TENS unit. The TENS unit was noted to not have provided satisfactory relief.

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 purchase/indefinite use:

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, H-Wave stimulation (HWT), page 117, which is part of the MTUS .

Rationale for the Decision:

The MTUS Chronic Pain Guidelines recommend an H-wave stimulator for chronic soft tissue inflammation if it is used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care. While the clinical documentation submitted for review indicates the patient has failed a TENS unit trial, it fails to include documentation that the patient has been unresponsive to conventional therapy other than the TENS unit, fails to include that the patient is in a program for functional restoration and fails to justify the necessity for purchase of this product. **The request for H-Wave purchase/indefinite use 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

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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.