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**Notice of Independent Medical Review Determination**

Dated: 9/30/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/2/2013

11/23/2010

7/16/2013

CM13-0001719

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 a purchase of an H-Wave device **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 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 left lower 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 7/16/13)
- Utilization Review Determination (dated 7/2/13)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

### **1) Regarding the request for a purchase of an H-Wave device:**

#### 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), H-wave Stimulation (HWT), pages 117-118, part of the 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 applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 11/23/2010 the employee sustained an industrial related injury, subsequent to a fall. A review of medical records indicates treatments have included: physical therapy, home exercise, medications, acupuncture and a trial of H-Wave. A report dated 4/4/13 documents that the employee is experiencing pain in the right wrist, left shoulder and decreased painful range of motion to the lumbar and cervical spine. A request was submitted for a purchase of an H-Wave device.

Chronic Pain Guidelines state “H-Wave stimulation criteria includes documented diagnosis of chronic soft tissue injury or neuropathic pain in an upper or lower extremity or the spine that is unresponsive to conventional therapies, including physical therapy, medication and TENS.” The medical records reviewed do indicate the failure of conservative therapy; however, the medical records do not document measurable objective functional gains to the employee’s lumbar and cervical spine, as well as right wrist. The submitted documentation does not support the need for the purchase of an H-Wave device. The request for purchase of an H-Wave device **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/db

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.