

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: 10/23/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/8/2013
Date of Injury:	8/6/2009
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003690

- 1) MAXIMUS Federal Services, Inc. has determined the request for an H-Wave unit one month trial for bilateral shoulders **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 unit one month trial for bilateral shoulders **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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, has a subspecialty in at least five years of experience providing direct patient care 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 8, 2013:

"This female patient was 35 years old on the listed claim date of 8/6/2009. The mechanism or injury was not provided. The patient complained of bilateral shoulder pain. The patient recently declined surgery. She has been receiving psychotherapy. The submitted records provided no evidence of prior trial of an electrical stimulator. I have been asked to review the request for a one-month trial of an H-wave."

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 Review (date 7/26/2013)
- Utilization Review Determination (date 7/8/2013)
- Medical Record from [REDACTED] (date 8/6/2013)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for an H-Wave unit one month trial for bilateral shoulders:

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 System section, which is part of the California Medical Treatment Utilization Schedule (MTUS). 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 was injured on 8/6/2009. The employee has continued pain in the shoulder and has undergone surgery for a rotator cuff partial tear. MRI shows another tear. The employee has tried physical therapy but there is no documentation of trial of a TENS unit or of a function restoration program. A request was submitted for an H-wave unit one month trial for bilateral shoulders.

The MTUS Chronic Pain Medical Treatment Guidelines state H-wave may be considered 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 records submitted and reviewed do not include documentation of a TENS trial or initiation of a functional restoration program. The employee does not meet the MTUS guidelines for the H-wave given the lack of documentation of failure of initially recommended conservative care. The request for H-wave unit one month trial for bilateral shoulders **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

/sab

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.