

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: 11/20/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/23/2013
Date of Injury:	6/5/2012
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006228

- 1) MAXIMUS Federal Services, Inc. has determined the request for **H-wave unit rental is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/23/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. 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 unit rental** 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.

Expert Reviewer Case Summary:

The Appellant is a 54 year old female who had an injury to the right knee on 6/5/12 in a fall downstairs while at work as a security guard. Her relevant past medical history includes right knee arthritis for "several years" the medical records of which were not provided; she reported the knee had been symptomatic but without substantially limiting her activities prior to that fall. She had no initial history documented of medical conditions that decrease healing capacity; subsequently peripheral vascular disease and obesity were discussed. She has allergies to Iodine and Lisinopril. She reported noting swelling of her feet and ankles. Physical and MRI findings support acute on chronic conditions including medial and lateral meniscus tears. On 7/26/2012 she received intra-articular Kenalog injection and was started on a walking program. The conservative treatments failed to resolve the condition and arthroscopic surgery was planned for 10/2/12 but did not take place due to a suspected Heart condition (Angina and CAD); the heart condition was not confirmed conditions when cleared for TKA in 2013. On 1/30/13, Total Right Knee Arthroplasty ("Replacement") was recommended due to advanced joint damage not considered amenable to arthroscopic treatment; it was performed on 5/10/13. In the postoperative records, there was no remark indicating there was a medication treatment failure. The report by Dr. [REDACTED] dated 6/18/13 stated the progress was "satisfactory recovery"; physical therapy "was requested but has not been initiated". The records did not document an active program of evidence-based functional restoration.

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 unit rental:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, H-wave stimulation (HWT), pgs. 117-118, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, pgs. 117-118, which are part of the MTUS.

Rationale for the Decision:

The criteria for coverage based upon a one month home trial for diabetic neuropathic pain is not applicable as there was no indication of diabetic neuropathic pain in this employee.

The criteria for coverage based upon a one month home trial for chronic inflammation is not applicable as there was no indication of chronic inflammation in this employee, because although symptoms were taking place over a long period of time, the surgery was recent enough that a new pattern of chronic inflammation as the source of pain was not yet established; the pain and inflammation is postoperative and was acute and subacute.

There was mention on the H-Wave request dated 7/11/13 that PT/exercise and medication were failures. Also, this request stated TENS "is not indicated". These outcome failures were not documented for these modalities of treatment in the records. The explanation of TENS not be indicated was not clarified by this or other records. There was no support for medication failure in the records. On 6/18/13 a report stated physical therapy, "was requested but has not been initiated". The records did not document the active program of evidence-based functional restoration. This report stated the progress was "satisfactory recovery". **the request for H-wave unit rental 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

/ldh

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.