

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/27/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/31/2013
Date of Injury: 1/10/2013
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008583

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 Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in Ohio and Texas. 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 is a 34 year old male who reported an injury on 01/10/013 caused when the patient moved a large cabinet. He has been diagnosed with lumbago, thoracic spine pain and disturbance of skin sensation. The patient has undergone 6 months of treatment to include medications, activity restrictions, and physical therapy. An MRI was performed on 04/23/2013 which revealed degenerative disc disease at L3-L4, L4-L5, and L5-S1 with lateral recess stenosis and central cord stenosis at L3-L4, L4-L5, and L5-S1 with entrapment of the L5 nerves at the lateral recesses and severe right neural foraminal stenosis at L5-S1 entrapping the right L5 nerve. The patient has noted continuing pain particularly when he ambulates or stands for an extended period of time. He utilized an H-Wave device beginning on 06/26/2013 for a 30-day trial which gave him relief and allowed him to rest. He is requesting an additional 3 months of use of the equipment.

IMR DECISION(S) AND RATIONALE(S)

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

1. Home H-Wave device additional three month is medically necessary and appropriate.

The Claims Administrator based its decision on the 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, H-Wave stimulation (HWT), pages 117-118, which is part of the MTUS.

The Physician Reviewer's decision rationale:

According to the CA MTUS, H-wave devices are recommended for chronic pain. The patient has stated, the use of the H-Wave stimulating device has allowed him the ability to sit for a longer period of time as well as relaxing his muscles enough for him to sleep better. Due to the positive effect the H-Wave has had on the patient's functional improvement, the continued use of this device for an additional three months is considered medically necessary. As such, the requested service is certified.

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.

[REDACTED]

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