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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/19/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/24/2013
Date of Injury:	2/9/2013
IMR Application Received:	8/8/2013
MAXIMUS Case Number:	CM13-0009153

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: PARTIAL OVERTURN. This means we decided that some (but not 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 Orthopedic Surgery and has a subspecialty in Shoulder and Elbow Surgery, 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 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 55 year old male who reported an injury on 02/09/2013 caused when he slipped and fell on ice. Prior imaging studies, including x-rays, an MRI and an MR arthrogram, found C5-C7 disc degeneration, L3-L4 disc degeneration, right elbow olecranon bursitis, and a full-thickness tear of the supraspinatus of the left shoulder, C3-C7 spondylosis with bilateral neural foraminal stenosis, and a right elbow contusion. According to the most recent exam date on 06/26/2013, the patient continued to complain of intermittent neck pain, daily and continuous low back pain which radiates into the right hip, severe left shoulder pain, and occasional pain in his right elbow. At that time, he was taking several oral medications to include Aspirin, Cyclobenzaprine, Fenofibrate, Hydrocodone-acetaminophen, Ibuprofen, Simvastatin, and Tramadol. The patient has already tried a TENS unit which did not relieve his pain, and participated in physical therapy and acupuncture. In July 2013, he participated in a 14 day trial of H-wave therapy in a clinical setting and stated that it was very helpful; improving his pain level by 3 points on a scale of 1-10/10.

IMR DECISION(S) AND RATIONALE(S)

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

1. H-wave unit rental for 30 days is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Section H-wave stimulation (HWT), pgs. 114-121, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section H-wave stimulation (HWT), pgs. 117-118, which is part of MTUS.

The Physician Reviewer's decision rationale:

According to MTUS Chronic Pain guidelines, a recent low quality meta-analysis concluded that the findings indicate a moderate to strong effect of the H-Wave device in providing pain relief, reducing the requirement for pain medication and increasing functionality, with the most robust effect observed for improved functionality, suggesting that the H-Wave device may facilitate a quicker return to work and other related daily activities. According to the H-wave compliance and outcome report dated 07/17/2013, the employee reported H-wave stimulator worked well on the muscles which relaxed and enabled the employee to sit for longer periods of time after using the device for 14 days. It also noted the employee was able to decrease pain medications and increase ability to perform activities of daily living. The MTUS guidelines indicate trial periods of more than one month should be justified by documentation submitted for review. Given the employee received benefit from the H-wave unit during the 14 days of the initial trial, an additional 30 days would be reasonable to help address pain while the employee awaits possible surgical intervention. **The request for an H-wave unit rental for 30 days is medically necessary and appropriate.**

2. Urine drug screen performed on 6/26/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines, Section Drug testing, pg. 43, which is part of MTUS, and, Official Disability Guidelines (ODG), Section Opioids, differentiation: dependence & addiction, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Drug Testing and Ongoing Management of Opioids, pgs. 43 & 78, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain guidelines indicate that drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs and for on-going management of opioids. The use of drug screening during inpatient treatment is recommended with issues of abuse, addiction, or poor pain control. The issue at dispute was whether the urine drug screen performed on 06/26/2013 was medically necessary. However, the only documentation provided for review that had any form of urinalysis results was a drug panel collected on 03/18/2013 which was consistent with the employee's prescribed medications. There are no other forms of documentation showing a second urine drug screen was performed or rationale to include suspicion of abuse, addiction or poor pain control to support performing a subsequent urine drug screen. Without this information, it is unclear what medications

the employee was being tested for. **The request for a Urine drug screen performed on 6/26/2013 is not medically necessary and appropriate.**

/reg

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.

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CM13-0009153