

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 10/7/2013

[Redacted]

[Redacted]

[Redacted]

Employee:	[Redacted]
Claim Number:	[Redacted]
Date of UR Decision:	6/7/2013
Date of Injury:	2/19/2013
IMR Application Received:	7/5/2013
MAXIMUS Case Number:	CM13-0000970

- 1) MAXIMUS Federal Services, Inc. has determined the requested Home H-Wave Device for the Neck **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/5/2013 disputing the Utilization Review Denial dated 6/7/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/5/2013. 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 requested Home H-Wave Device for the Neck **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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 June 7, 2013

“This is a 55 year old male with an injury date of 2119/13 per referral. Per the 3/19113 EDS, impression is bilateral compression of the median nerve at the carpal tunnel. Left mild compression of the ulnar nerve at or near the medial epicondyle. Per the 5/22113 progress report, the claimant has complaints of pain and exhibits impaired ADL's. He has a diagnosis of cervical pain.”

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 dated 7/05/2013
- Utilization Review Determination provided by [REDACTED] dated 6/07/2013
- No Medical Records were provided for this review
- ACOEM Guidelines, 2004, 2nd Edition, Neck and Upper Back Complaints, Chapter 8, page 181, Table 8-8
- Official Disability Guidelines (ODG), Pain Chapter, H-Wave Stimulation (HWS)

1) Regarding the request for Home H-Wave Device for the Neck:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2004, 2nd

Edition, Neck and Upper Back Complaints, Chapter 8, page 181, Table 8-8, of the MTUS, and Official Disability Guidelines (ODG), Current Version, Pain Chapter, H-Wave Stimulation (HWS), a medical treatment guideline (MTG) not in the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported an injury to his left wrist on 2/19/2013. A report dated 3/19/2013 revealed a bilateral compression of the medial nerve at the carpal tunnel and left mild compression of the ulnar nerve at or near the medial epicondyle. The request was made for a home H-Wave Device for the Neck.

MTUS Guidelines do not recommend H-Wave Devices as an isolated intervention, but may be considered as a non-invasive conservative option for diabetic neuropathic pain, if used as an adjunct to a program of evidenced-based functional restoration, and only following failure of other recommended pain modalities. There are no submitted records documenting the use of other modalities or diabetic neuropathy. The requested Home H-Wave Device for the neck 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

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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.