

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/30/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/29/2013
Date of Injury: 8/8/20047
IMR Application Received: 8/14/2013
MAXIMUS Case Number: CM13-0010967

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: UPHOLD. This means we decided that none 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 PM&R, and is licensed to practice in Pennsylvania. 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 underlying date of injury in this case is 12/08/2004. The primary treating diagnosis is carpal tunnel syndrome. This patient previously was approved for an H-Wave trial because the patient had persistent edema, pain, and restricted range of motion of the right elbow, forearm, and upper arm despite extensive past treatment including physical therapy, acupuncture, and TENS unit. An initial physician review notes that the treating provider included a discussion that the patient has edema and tenosynovitis and the only thing he reported gives him relief is an H-Wave device. That physician reviewer noted that the benefit from an H-Wave trial was not clearly supported and therefore recommended that the request be non-certified.

A treating physician Peer-2 form of 06/06/2013 notes that the patient had stopped using H-Wave because it was no longer approved, and the patient had been getting significant pain relief while using the H-Wave. The treating provider concluded that the patient had excellent results with the use of an H-Wave with significant improvement of pain and functional mobility and thus this device should be purchased.

IMR DECISION(S) AND RATIONALE(S)

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

1. H-Wave purchase for the right elbow and right wrist is not 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, Section on H-Wave Stimulation, page 117, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines, section on H-Wave stimulation, page 117, states, "*A one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration.*" At this time the reports of functional benefit from an H-Wave trial appear to be subjective or not verifiable and not consistent with the California Medical Treatment Utilization Schedule Guidelines for documentation of functional benefit as per section 92.20. It may be a consideration for the treating provider to submit a new request clarifying objectively and verifiably what specific functional benefit the patient received from the past H-Wave trial. At this time, given that this information is not present, the treatment is not medically necessary.

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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