

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

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Dated: 12/17/2013

IMR Case Number:	CM13-0016167	Date of Injury:	01/12/2012
Claims Number:	██████████	UR Denial Date:	08/12/2013
Priority:	STANDARD	Application Received:	08/26/2013
Employee Name:	██		
Provider Name:	██████████ MD		
Treatment(s) in Dispute Listed on IMR Application:			
H-WAVE STIMULATION UNIT FOR HOME USE; RIGHT ELBOW AND WRIST			

DEAR ████████████████████ ,

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, ████████████████████
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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 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator, employee
- Medical Treatment Utilization Schedule (MTUS)

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 claimant is a 62 year old female injured January 12, 2012 sustaining an injury to the right upper extremity and right elbow. The current progress report for review of August 5, 2013 gives a current working diagnosis of right wrist carpal tunnel syndrome, right elbow cubital tunnel syndrome and right elbow medial epicondylitis. It states the claimant is currently being treated with medication management and activity restrictions, describing increased complaints of pain about the right elbow radiating to the right upper arm. The physical examination showed 0 to 140 degrees right elbow motion with tenderness to palpation over the lateral aspect and a positive Tinel's sign. The right wrist was with 5 degrees to 85 degrees motion with positive Tinel's and Phalen's testing. The recommendation was for an H-Wave stimulator device for the claimant's ongoing diagnosis for a trial period stating failed conservative care including a year of a TENS unit, physical therapy and acupuncture. The last clinical record is October 12, 2013 to whom it may concern letter from the claimant stating she had been utilizing the H-Wave device for the past one month noting a 10% to 15% improvement stating "the more I use my arm the pain and discomfort increases."

IMR DECISION(S) AND RATIONALE(S)

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

1. H-Wave stimulation Unit for Home Use; Right Elbow and Wrist is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS Chronic Pain Medical Treatment Guidelines, Section 9792.24.2, which is part of the MTUS.

The Physician Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Page 117, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Guidelines continued use of an H-Wave device is not supported. The guidelines do recommend a one month trial of a device for chronic soft tissue inflammation. The letter written by the employee in the employee's own words indicates only a 10% to 15% improvement with continued pain and discomfort with activity. This statement from the employee would not support benefit from the device, thus negating its need for further long term use. **The request for an H-Wave stimulator for home use of the right elbow and right wrist is not medically necessary and appropriate.**

/jb

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]