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**Notice of Independent Medical Review Determination**

Dated: 10/1/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	2/9/2012
IMR Application Received:	7/22/2013
MAXIMUS Case Number:	CM13-0002048

- 1) MAXIMUS Federal Services, Inc. has determined the request for H-wave unit for hand **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 request for H-wave unit for hand **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 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 July 12, 2013:

#### "Clinical Features:

- a. The patient is a 61 year old female s/p injury 2/9/12, now 17 months ago.
- b. Per PM&R report dated 6/19/2013; there are problems. finding an Ortho Hand surgeon in MPN. She has continued pain radial aspect wrist radiating up to the arm with no relief.
- c. Objective - unchanged.
- d. Work status: TTD
- e. With regard to Orthopedic Consultation:
  - i. There is continued wrist pain radiating up the arm .
  - ii. There has been prior left wrist surgery.
  - iii. In this scenario, with ongoing symptoms and prior surgery, an orthopedic consultation is considered medically necessary.
  - iv. Therefore, the request is supported as medically necessary and is approved
- f. With regard to H-Wave Unit for hand:
  - i. There is ongoing wrist pain.
  - ii. There are no impairments of ADLs documented.
  - iii. The diagnosis includes tendonitis; she is s/p left wrist surgery.
  - iv. There is no mention of diabetic neuropathy or chronic inflammation
  - v. There is no mention of a home exercise program or other functional improvement based treatment.
  - vi. There is no mention of a successful trial of generic TENS or other electrostimulation treatment in a clinic or physical therapy facility. Testimonial benefit is acknowledged. However, a successful trial means one resulting in objective functional improvement.
  - vii. There is no mention of a trial of modified work."

### **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 (received 7/22/2013)
- Utilization Review Determination from [REDACTED] (dated 7/12/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

### **1) Regarding the request for H-wave unit for hand:**

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, (2009), pg. 114-118, part of the Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG), (current version), (specific citation not provided), a medical treatment guideline (MTG), not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

#### Rationale for the Decision:

The employee sustained a work-related injury on 2/09/12. The submitted and reviewed medical records document left wrist pain radiating up the arm. The records indicate diagnoses include multiple areas of tendinitis and ligamentous wrist injury. The employee is status post-surgery and treatment has included medications. A request has been submitted for H-wave unit for hand.

MTUS Chronic Pain guidelines note that a one-month home-based trial of H-wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation (TENS). The submitted medical records lack evidence of a recent thorough wrist examination and do not document failure of conservative measures (TENS unit, physical therapy or anti-inflammatories) as recommended by the guidelines. The request for an H-wave unit for the hand **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/srb

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.