MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

1) MAXIMUS Federal Services, Inc. has determined the requested OrthoStim4 EOC1, EOC2 purchase and supplies **are not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the requested physical therapy two (2) times a week for four (4) weeks **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the requested Fexmid 7.5 mg **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/29/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 5/30/2013. 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 OrthoStim4 EOC1, EOC2 purchase and supplies **are not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the physical therapy two (2) times a week for four (4) weeks **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the requested Fexmid 7.5 mg **is 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 Occupational Medicine 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 May 15, 2013.

"Mr. [redacted] was born on [redacted]. His underlying date of injury is 02/20/13. His diagnoses include a left shoulder parascapular strain with impingement with a partial tear of the supraspinatus tendon and superior labral tear, subacromial bursitis, acromioclavicular osteoarthritis, and probably perforation or tear of the inferior femoral capsule.

"On 04/05/13, Dr. [redacted] noted the patient had failed conservative treatment and he requested the authorization for left shoulder arthroscopic decompression.

"On 4/18/13, a peer review certified a left shoulder arthroscopic decompression with distal clavicle resection and labral tear and possible rotator cuff repair. That review noted that an MRI of 3/21/13 showed a partial undersurface tear of the supraspinatus with subacromial bursitis and had advanced acromioclavicular arthritis and superior labral tear.

"On 4/24/13, a prescription for an Ortho Stim unit by Dr. [redacted] states that a prior unit broke and that the patient has a left shoulder sprain/strain and a labral tear.

"A Doctor's First Report from Dr. [redacted] bears a fax date of 05/15/13 and describes an injury of 2/20/13 when the patient was pulling a steam cleaner with deflated tires which was hard to roll. The patient felt a pop followed by pain in his left shoulder. Subsequently an MRI of the left shoulder of 3/21/13 showed abnormal findings. The patient continued with pain in the left shoulder. On exam by Dr. [redacted] the patient had tenderness in the parascapular muscle with subacromial crepitus and with globally reduced range of motion and associated pain and reduced strength. Dr. [redacted] noted that the patient was hesitant to undergo surgery and decided to seek treatment for a second opinion and he did have conservative treatment prior to surgery."

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 5/29/13)
- Utilization Review Determination from [redacted] (dated 5/17/13)
- Employee medical records from [redacted] (dated 2/20/13 – 4/5/13)
- Employee medical records from [redacted] MD (dated 4/24/13-6/4/13)
- Employee medical records from [redacted] (dated 3/21/13)
- Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) pg. 34,35
- Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pg 203
- 9792.24.2. Chronic Pain Medical Treatment Guidelines (May 2009), Part 2, Pain Interventions and Treatments, pg. 41-42, 58-60, 118-121

1) **Regarding the request for OrthoStim4 EOC1, EOC2 purchase and supplies:**

<u>Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision</u>
The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Shoulder Chapter, Interferential current stimulation (ICS), which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 121 of 127, of the Medical Treatment Utilization Schedule was applicable and relevant to the issue at dispute.

<u>Rationale for the Decision:</u>

The Employee injured the left shoulder in an industrial injury on February 28, 2013. The medical records provided and reviewed indicate treatment has consisted of analgesic/adjuvant medications; an MRI of the left upper arm on March 21, 2013, which was notable for the absence of any significant abnormalities involving the humerus; an MRI of the left shoulder on March 21, 2013, which was notable for partial undersurface tear of supraspinatus with associated superior labral tear; and several sessions of physical therapy. Review of the April 24, 2013 medical record from a new primary treating physician indicates the employee has only had two sessions of the currently approved physical therapy.

The Employee's injury was greater than four (4) months ago, meeting the criteria for chronic pain. The OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. The Chronic Pain Guidelines only recommend Neuromuscular stimulation in the post stroke rehabilitative context. Galvanic stimulation is considered investigational for all purposes and is not recommended by the Chronic Pain Guidelines. Since several components of the device are not recommended by the MTUS, the OrthoStim4 EOC1, EOC2, purchase and supplies, **is not medically necessary and appropriate.**

2) **Regarding the request for physical therapy two (2) times a week for four (4) weeks:**

<u>Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision</u>
The Claims Administrator based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), and Ankle and Foot Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 14) of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 99 of 127, of the Medical Treatment Utilization Schedule was applicable and relevant to the issue at dispute.

<u>Rationale for the Decision:</u>
The Employee injured the left shoulder in an industrial injury on February 28, 2013. The medical records provided and reviewed indicate treatment has consisted of analgesic/adjuvant medications; an MRI of the left upper arm on March 21, 2013, which was notable for the absence of any significant abnormalities involving the humerus; an MRI of the left shoulder on March 21, 2013, which was notable for partial undersurface tear of supraspinatus with associated superior labral tear; and several sessions of physical therapy. Review of the April 24, 2013 medical record from a new primary treating

physician indicates the employee has only had two sessions of the currently approved physical.

The Employee's injury was greater than four (4) months ago, meeting the criteria for chronic pain. MTUS Chronic Pain Medical Treatment Guidelines indicate physical therapy for myalgias and/or myositis of various body parts should be limited to a course of nine (9) to ten (10) treatments. The medical records provided and reviewed indicate the employee has had treatment in excess of these amounts. A request for authorization on February 28, 2013 suggests that 12 sessions of physical therapy were requested; the medical report of March 29, 2013 suggests that an additional 9 sessions of therapy be pursued. Based on the review of medical records provided, the Employee appears to have had prior treatment in excess of that indicated by MTUS. There is no evidence of functional improvement as defined in MTUS which would justify extension of treatment beyond the guidelines. The requested physical therapy, two (2) times a week for four (4) weeks, **is not medically necessary and appropriate.**

3) Regarding the request for Fexmid 7.5 mg

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated the Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 41 of 127, of the Medical Treatment Utilization Schedule was applicable and relevant to the issue at dispute.

Rationale for the Decision:

The Employee injured the left shoulder in an industrial injury on February 28, 2013. The medical records provided and reviewed indicate treatment has consisted of analgesic/adjuvant medications; an MRI of the left upper arm on March 21, 2013, which was notable for the absence of any significant abnormalities involving the humerus; an MRI of the left shoulder on March 21, 2013, which was notable for partial undersurface tear of supraspinatus with associated superior labral tear; and several sessions of physical therapy. Review of the April 24, 2013 medical record from a new primary treating physician indicates the employee has only had two sessions of the currently approved physical.

The Employee's injury was greater than four (4) months ago, meeting the criteria for chronic pain. MTUS Chronic Pain Medical Treatment Guidelines indicate cyclobenzaprine (Fexmid), is recommended as a short course of therapy and for

brief use purposes to treat acute flare ups of pain. The requested Fexmid 7.5 mg **is 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.