

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/17/2013
Date of Injury:	2/2/2013
IMR Application Received:	6/18/2013
MAXIMUS Case Number:	CM13-0000749

- 1) MAXIMUS Federal Services, Inc. has determined the request for **home orthopedic stimulation unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/18/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/22/2013. 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 **home orthopedic stimulation unit 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 Oklahoma. 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.

Expert Reviewer Case Summary:

The patient is a 39-year-old female with a date of injury of 02/02/2013. The patient reports that while typing at work she experienced sharp pain in her right elbow and forearm. She has been followed as an outpatient and her care has included use of wrist and elbow braces, injection for pain with noted improvement, a short course of approximately 4 therapy sessions, and modified work duty. Right elbow exam findings revealed tenderness to palpation over the lateral epicondyle and extensor muscle group of proximal forearm with a positive Cozen's test. Right wrist exam findings included dorsal pain and positive Phalen's secondary to and the presence of a tender right wrist dorsal ganglion cyst. Sensation to pinprick and light touch were intact, there was no weakness in gross motor testing of the major muscle groups in both upper extremities. Reflexes were diminished at 1+ bilateral in the upper extremities. The patient was diagnosed with right elbow lateral epicondylitis and right wrist dorsal ganglion cyst. The patient's physician deemed her temporarily totally disabled and the use of a home ortho stimulation unit was advised. This request was previously denied secondary to lack of support by the California Medical Treatment Utilization Schedule for the use of high volt galvanic neuromuscular electrical stimulation and pulsed direct current for pain control and lateral epicondylgia.

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

1) Regarding the request for 1 home ortho stimulation unit:

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 Official Disability Guidelines, (ODG), Pain, Chronic, Galvanic stimulation, which is not part of MTUS.

The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines, Galvanic Stimulation, Interferential Current Stimulation (ICS) and Microcurrent electrical stimulation (MENS devices), pages 117, 120-121, and the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, Elbow Disorders. In. Hegmann K (Ed), Occupational Medicine Practice Guidelines, 2nd Ed (2007 Revision), pages 33-40, which is part of the MTUS.

Rationale for the Decision:

This request was previously denied secondary to lack of support by the California Medical Treatment Utilization Schedule for the use of high volt galvanic neuromuscular electrical stimulation and pulsed direct current for pain control and lateral epicondylalgia. Due to the employee's diagnosis of right elbow lateral epicondylitis and right wrist dorsal ganglion cyst, the employee continues to have complaints of sharp pain in the right elbow and forearm. A previous course of conservative treatment including wrist and elbow braces, injections, and therapy have proven to be unsuccessful to this point. In an effort to avoid surgery, orthopedic stimulation has been recommended. Orthopedic stimulation is believed to be comprised of a variety of modalities to include interferential current stimulation, high-volt Galvanic, neuromuscular electrical stimulation and pulsed direct current. The California Medical Treatment Utilization Schedule indicates that there are no quality studies available for soft tissue mobilization, biofeedback, transcutaneous electrical nerve stimulation, or electrical stimulation for lateral epicondylalgia and benefits have therefore not been shown. These options are moderately costly, have few side effects and are noninvasive. CA MTUS Chronic Pain Medical Treatment Guidelines do not support the use of microcurrent electrical stimulation or high volt galvanic neuromuscular electrical stimulation. Thus, there is no recommendation for them. As such, the request for 1 home ortho stimulation unit is not supported by the California Medical Treatment Utilization Schedule. **The request for a home orthopedic stimulation unit 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/pas

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.