

**MAXIMUS FEDERAL SERVICES, INC.**

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



**Notice of Independent Medical Review Determination**

Dated: 5/23/2013

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

- 1) MAXIMUS Federal Services, Inc. has determined the 9 physical therapy sessions requested **are medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the 6 acupuncture treatments requested **are medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the tennis elbow support requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Ketoprofen lotion requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the X-ray of the left elbow requested **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 3/19/13 disputing the Utilization Review Denial dated 3/13/13. A Notice of Assignment and Request for Information was provided to the above parties on 4/23/13. 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 9 physical therapy sessions requested **are medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the 6 acupuncture treatments requested **are medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the tennis elbow support requested **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the Ketoprofen lotion requested **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the X-ray of the left elbow requested **is not medically necessary and appropriate.**

### **Medical Qualifications of the Professional 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 professional 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 March 13, 2013

According to the medical records, the patient is a 59-year-old male who sustained an industrial injury on January 27, 2013.

According to a doctor's first report by [REDACTED], DO, dated January 28, 2013, standard 3 view x-rays of the left elbow were obtained. Preliminary interpretation of these x-rays are normal-no fracture.

The patient underwent an orthopedic consultation with [REDACTED] on February 27, 2013, at which time he complained of pain in the lateral aspect of the left elbow which is a constant ache, especially at night. Examination demonstrates slight lateral swelling and tenderness over the lateral epicondyle and in the extensor wad muscles of the left forearm, full extension, limited flexion to 100 degrees due to pain, normal supination, limited pronation to 60 degrees due to pain, positive resisted wrist extension test, normal sensation, and decreased grip strength in the left hand compared to the right. X-rays of the left elbow were obtained in office today and are normal. There is a negative fat pad sign. The patient was diagnosed with left elbow lateral epicondylitis.

#### **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 IMR
- Physician Peer Review conducted by [REDACTED]. (dated 3/13/13)
- Medical Records from [REDACTED] (dated 2/27/13, 4/31/13)
- Medical Records from [REDACTED] (dated 1/27/13 – 2/27/13)

#### **1) Regarding the Request for 9 physical therapy sessions:**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), (2007), pg. 25-26 and Official Disability Guidelines (ODG), (2009), Elbow and Physical Therapy Chapters, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found that the American College of Occupational and Environmental Medicine (ACOEM), (2007), Chapter 10, Elbow Disorders (Revised), Page 603 was more appropriate for the employee's clinical circumstance.

### Rationale for the Decision

The employee demonstrates symptoms consistent with lateral epicondylitis of the left elbow following an industrial injury. Five sessions of physical therapy have been completed as of 2/27/13 with little improvement in symptoms. A report authored by the provider dated 4/3/13 state the employee is not able to work because there is no modified duty available. The provider disputed the denial of additional physical therapy by the Claims Administrator stating that every effort should be made to deal with this condition in a conservative manner providing every alternative treatment before resorting to surgical intervention. Continuation conservative management in the form of additional physical therapy is medically appropriate to attempt to avoid the need for surgical intervention, which should only be considered after failure of conservative care has been demonstrated. ACOEM (2007), Elbow Chapter, pg. 603 states conservative care should be maintained for a minimum of 3–6 months in patients with lateral epicondylitis. The request for 9 physical therapy sessions is medically necessary and appropriate.

## **2) Regarding the Request for 6 acupuncture treatments:**

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

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines (2009) of the Medical Treatment Utilization Schedule (MTUS). The provider disputed these guidelines and utilized the Official Disability Guidelines (2009). The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

### Rationale for the Decision

The employee demonstrates symptoms consistent with lateral epicondylitis of the left elbow following an industrial injury. Five sessions of physical therapy have been completed as of 2/27/13 with little improvement in symptoms. A report authored by the provider dated 4/3/13 states the employee is not able to work because there is no modified duty available. Acupuncture either alone or in conjunction with physical therapy is used as a conservative measure to promote "functional improvement". "Functional improvement" is defined by the California Medical Treatment Utilization Schedule (CA MTUS) guidelines, Section 9792.20 as a significant improvement in activities of daily living and a reduction in work restrictions as measured during clinical history and physical exam. The Acupuncture Medical Treatment Guidelines (2009) state acupuncture may be used in conjunction with physical rehabilitation to hasten functional recovery and to reduce pain, inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient and reduce muscle spasm. The guidelines allow the use of

acupuncture for musculoskeletal conditions for a frequency and duration of treatment as follows: Time to produce functional improvement of 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. The request for 6 acupuncture treatments is medically necessary and appropriate.

**3) Regarding the Request for tennis elbow support:**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), (2007), pg. 26 of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

ACOEM Guidelines (2007), pg. 26, Epicondylalgia Supports, suggest that although there is insufficient evidence to support their use, they are recommended. The clinical documentation provided for review indicates the employee was supplied with a Bandit Tennis Elbow strap on 1/28/13. The requested tennis elbow support is considered redundant and is not medically necessary and appropriate.

**4) Regarding the Request for Ketoprofen lotion:**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), (2007), pg. 49 and Official Disability Guidelines (ODG) (2009), Pain Chapter, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced sections of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

Ketoprofen is not currently FDA approved for topical application. ODG (2009) Guidelines, Pain Chapter states although topical Ketoprofen is approved for use by the European FDA and NICE guidelines, it is not FDA approved for use in the United States. The Chronic Pain Guidelines (2009) state Ketoprofen is not approved for a topical application and has an extremely high incidence of photocontact dermatitis and photosensitization reactions. The request for Ketoprofen lotion is not medically necessary and appropriate.

**5) Regarding the Request for X-ray of the left elbow:**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), (2007), pg. 33 and Official Disability Guidelines (ODG), Chapter 10, Elbow Chapter, Radiographs (X-rays), of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

X-ray reports were not included in the clinical notes supplied for this review. After review of the clinical notes, two X-rays were undertaken and reported as normal by two clinicians on two separate occasions. On 1/28/13 the x-ray was reported as normal. On 2/27/13 an additional x-ray was performed to look for possible occult fractures. This X-ray was reported as normal with no fractures noted. ACOEM Guidelines (2007), Elbow Chapter states that imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. There is no indication in the medical records that there has been a new trauma or injury that would change the diagnosis and subsequent treatment of lateral epicondylitis. The request for X-ray of the left elbow 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

/lkh

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.