

Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/22/2013
Date of Injury: 12/29/2009
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011809

- 1) MAXIMUS Federal Services, Inc. has determined the request for **1 Flector 1.3% Adhesive Patch SIG: One patch to skin daily as needed. QTY 30.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy for the neck and right upper extremity (RUE) times 16 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit (DOS 07/08/2013) is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/30/2013. 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 request for **1 Flector 1.3% Adhesive Patch SIG: One patch to skin daily as needed. QTY 30.00 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy for the neck and right upper extremity (RUE) times 16 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **TENS unit (DOS 07/08/2013) 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 & 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.

Expert Reviewer Case Summary:

The patient is a 50-year-old female who reported an injury on 12/29/2009 due to pulling vaults and hitting her right arm, shoulder, and back while performing normal job duties. The patient was treated conservatively with medications, physical therapy, and cervical epidural steroid injections that provided no significant relief. The patient underwent shoulder arthroscopic surgery on 09/27/2009 and right shoulder manipulation under anesthesia in 04/2010 that provided moderate pain relief. The patient had increasing right neck and shoulder pain, decreasing her ability to participate in regular activities. Physical findings included limited range of motion described as 160 degrees in flexion, 30 degrees in extension, and 170 degrees in abduction due to pain. The patient had a positive Hawkins' test and Neer's test. Tenderness to palpation in the biceps groove and subdeltoid bursa was also noted. The patient had decreased sensation to light touch in the C5 dermatome distribution on the right side. The patient's diagnoses included cervical radiculopathy, cervical facet syndrome, shoulder pain, and muscle spasms. The patient's treatment plan included medications and continued injections.

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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - ☒ Claims Administrator
 - ☒ Employee/Employee Representative
 - ☒ Provide

1) Regarding the request for 1 Flector 1.3% Adhesive Patch SIG: One patch to skin daily as needed. QTY 30.00:

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, Flector patch, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Topical Analgesics, page 111, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicates that the employee continues to have pain that interferes with the employee's ability to participate in activities of daily living. The requested Flector patch contains topical non-steroidal anti-inflammatory drugs (NSAIDs). The California MTUS states "there is little evidence to use topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder." Additionally, NSAIDs are not recommended for neuropathic pain as there is little scientific evidence to support their efficacy. Further, the documentation provided for review does not provide evidence that the employee's pain has failed to respond to first line oral analgesics and there is no documentation of functional benefit or pain relief as a result of this medication. **The request for 1 Flector 1.3% Adhesive Patch SIG: One patch to skin daily as needed, QTY 30.00 is not medically necessary and appropriate.**

2) Regarding the request for physical therapy for the neck and right upper extremity (RUE) times 16:

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 Chronic Pain Medical Treatment Guidelines, pg. 99 Physical Medicine, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: Physical Medicine, page 99, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicates that the documentation provided for review does provide evidence that the employee has restricted range of motion and pain complaints. The California MTUS recommends physical therapy as a conservative measure to help control pain symptoms and to restore function and range of motion. However, it is noted within the documentation that the employee previously underwent physical therapy. There is no evidence of functional benefit as a result of the previously applied physical therapy. Additionally, as a result of the prior rehabilitation, the employee should be well-versed in a home exercise program. The clinical documentation does not include any evidence that the employee is participating in a home exercise program. Further, there are no barriers noted to preclude further progress of this employee while participating in a home exercise program. **The request for Physical Therapy for the neck and right upper extremity (RUE) times 16 is not medically necessary and appropriate.**

3) Regarding the request for TENS unit (DOS 07/08/2013):

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 Chronic Pain Medical Treatment Guidelines, pgs. 114-116 transcutaneous electrotherapy, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines: TENS (transcutaneous electrical nerve stimulation), Chronic Pain, page 114, which is a part of the MTUS.

Rationale for the Decision:

A review of the records indicates that the employee continues to have increasing pain complaints and range of motion deficits. The California MTUS does not recommend a TENS unit as a primary treatment modality but is considered an adjunct therapy to evidence-based functional restoration programs. The clinical documentation submitted for review does not provide evidence that the employee was participating in a functional restoration program, to include a home exercise program on 07/08/2013. Additionally, the documentation does not support that the employee is receiving any functional benefit from this treatment modality. **The request for TENS unit (DOS 07/08/2013) 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

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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.