

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: **12/2/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/7/2013  
Date of Injury: 12/7/2010  
IMR Application Received: 8/12/2013  
MAXIMUS Case Number: CM13-0012507

- 1) MAXIMUS Federal Services, Inc. has determined the request for a **Surgi stim unit for 90 days is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase of a cold therapy unit is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/7/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 a **Surgi stim unit for 90 days** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **purchase of a cold therapy 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 Orthopedic Surgery, has a subspecialty in Spine Surgery 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 24 year old female who reported an injury on December 7, 2010. The mechanism of injury involved a slip and fall. The patient has received 14 sessions of physical therapy, six visits of chiropractic manipulative therapy, one cortisone injection, and various anti-inflammatory and analgesic medications. An MRI scan of the patient's left shoulder was obtained on January 10, 2011 which indicated delamination tearing involving the supraspinatus portion of the rotator cuff and type 2 SLAP tearing. The patient's current diagnoses include left shoulder strain, impingement, SLAP 2 glenoid labrum, left wrist carpal tunnel syndrome, and 1 mm to 1.5 mm disc osteophyte at C4 to C6. Physical examination revealed tenderness to palpation, positive impingement testing, positive Tinel's and Phalen's testing of the left wrist, and decreased range of motion. A review letter was submitted on August 7, 2013 for the requested services including outpatient surgical intervention. Outpatient durable medical equipment was denied at that time.

### **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 Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for a Surgi stim unit for 90 days:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 116-117, which are a part of MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines state postoperative transcutaneous electrical nerve stimulation is recommended as a treatment option for acute postoperative pain in the first 30 days post surgery. Transcutaneous electrical nerve stimulation appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period. As per the clinical notes submitted, a Surgi stim 90-day unit was requested to promote positive outcomes and provide symptomatic management based on evidence published in an article. There is no indication in the medical records provided for review as to why this employee would not benefit from a 30 day rental as opposed to a 90 day purchase. **The request for a Surgi stim unit for 90 days is not medically necessary and appropriate.**

**2) Regarding the request for purchase of a cold therapy unit:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Shoulder Chapter, Online Edition.

Rationale for the Decision:

The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days, including home use. As per the clinical notes submitted for review, there is no indication as to why this employee would not benefit from a postoperative 7-day use of continuous flow cryotherapy as opposed to a unit purchase. The medical necessity has not been established. **The request for purchase of a cold therapy 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

/dso

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.