

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/14/2013
Date of Injury:	3/4/2011
IMR Application Received:	8/21/2013
MAXIMUS Case Number:	CM13-0014452

- 1) MAXIMUS Federal Services, Inc. has determined the request for **2 pro wrist support is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 X-force stimulator is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **3 batteries is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **1 conductive garment is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/21/2013 disputing the Utilization Review Denial dated 8/14/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/2/2013. 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 **2 pro wrist support** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 X-force stimulator** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **3 batteries** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **1 conductive garment** 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, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Illinois, Indiana, and Texas. 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 55-year-old male who reported an injury on 03/04/2011. The mechanism of injury is not specifically stated. Diagnoses include status post open rotator cuff repair on 03/17/2011, left elbow internal derangement and lateral epicondylitis, left wrist sprain and strain with internal derangement, cervical strain with disc lesion of the cervical spine with radiculitis and radiculopathy, and status post arthrodesis instrumentation of lumbar spine in 09/2007, work related. A supplemental report was submitted on 05/02/2013 by Dr. [REDACTED]. It was noted that the patient completed a functional capacity evaluation on 04/25/2013. The patient was able to work with restrictions, including 4 hours to 6 hours of reaching and 6 hours to 8 hours of standing, walking, sitting, bending, squatting, twisting, crawling, driving, grasping, and pushing and pulling. He was restricted to no lifting or carrying at a height of 5 feet to 6 feet more than 25 pounds for more than 2 hours to 4 hours a day. Work restrictions were issued on a permanent basis. A previous supplemental report was also submitted on 04/15/2013. A progress note by Dr. [REDACTED] on 12/23/2012 indicated a diagnosis of status post open rotator cuff repair in 03/2011. The patient presented at that time with complaints of neck pain radiating to bilateral upper extremities as well as numbness and tingling in fingertips of bilateral hands. Recommendations included cervical epidural steroid 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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for 2 pro wrist support :**

##### 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 Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11), pages 263-264, which is part of the MTUS, and the Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, Online Edition, which is not part of the MTUS.

##### Rationale for the Decision:

The MTUS/ACOEM Practice Guidelines state initial care for employees with forearm, wrist, and hand complaints includes non-prescription analgesics for employees with acute or subacute symptoms. If treatment response is inadequate, prescribed pharmaceuticals or physical methods may be added. Day splints can be considered for employee's comfort as needed to reduce pain along with work modifications. Initial treatment of carpal tunnel syndrome should include night splints. Official Disability Guidelines state splints are recommended for treating displaced fractures. Immobilization is standard for fracture healing, although employee satisfaction is higher with splinting rather than casting. As per the clinical notes submitted, there is no evidence of carpal tunnel syndrome or displaced fracture that would warrant the need for a splint at this time. Additional information was requested in 07/2013 regarding the provider's request for the above service, the employee's subjective and objective status at the time of the request, and the provider's clinical rationale supporting the medical necessity of the request. At this time, the requested information has not been received. Therefore, the request cannot be determined as medically appropriate. **The request for 2 pro wrist support is not medically necessary and appropriate.**

#### **2) Regarding the request for 1 X-force stimulator:**

##### 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, pages 114-117, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. A home-based treatment trial of 1 month may be appropriate for neuropathic pain and CRPS-II. Criteria for the use of a TENS unit includes chronic intractable pain, documentation of pain at least 3 months in duration, evidence that other appropriate pain modalities have been tried and failed, and other ongoing pain treatment should also be documented during the trial period. A treatment plan including the specific short and long term goals of treatment with the TENS unit should be submitted. As per the clinical notes submitted, there is no recent physical examination provided for review. Therefore, the medical necessity for the requested treatment has not been established. There is also no evidence of this employee's current active participation in a functional restoration program to be used as an adjunct to the TENS therapy. There is no evidence of a failure to respond to previous conservative treatment. Treatment plan including specific short and long term goals of treatment with the unit is not provided. Based on the clinical information received and the California MTUS Guidelines, the request is not recommended. **The request for 1 X-force stimulator is not medically necessary and appropriate.**

**3) Regarding the request for 3 batteries:**

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, pages 114-117, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. A home-based treatment trial of 1 month may be appropriate for neuropathic pain and CRPS-II. Criteria for the use of a TENS unit includes chronic intractable pain, documentation of pain at least 3 months in duration, evidence that other appropriate pain modalities have been tried and failed, and other ongoing pain treatment should also be documented during the trial period. A treatment plan including the specific short and long term goals of treatment with the TENS unit should be submitted. As per the clinical notes submitted, there is no recent physical examination provided for review. Therefore, the medical necessity for the requested treatment has not been established. **The request for 3 batteries is not medically necessary and appropriate.**

**4) Regarding the request for 1 conductive garment:**

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, pages 114-117, which is part of the MTUS.

Rationale for the Decision:

The MTUS Guidelines state form-fitting TENS device is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the employee has medical conditions that prevent the use of a traditional system, or the TENS unit is to be used under a cast. As per the clinical notes submitted, the employee does not meet any of the above-mentioned criteria for a form-fitting TENS device. Based on the clinical information and the California MTUS Guidelines, the request is not recommended. **The request for 1 conductive garment 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

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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.