

Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

[REDACTED]

[REDACTED]

Date of UR Decision:

8/9/2013

Date of Injury:

1/11/2013

IMR Application Received:

8/27/2013

MAXIMUS Case Number:

CM13-0016963

- 1) MAXIMUS Federal Services, Inc. has determined the request for **1 Paraffin Wax Unit is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 heat pad is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 interferential unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/27/2013 disputing the Utilization Review Denial dated 8/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 Paraffin Wax Unit is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **1 heat pad is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **1 interferential 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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 56-year-old female who sustained an injury on 1/11/2013 due to repetitive job duties. The patient is diagnosed with bilateral carpal tunnel syndrome and cervical strain and radiculopathy. She underwent a left carpal tunnel release on 4/25/13. The EMGINCY of the upper extremities dated Sept. 2012 revealed severe pathology of the median nerve of the right wrist, consistent with right carpal tunnel syndrome. Decompression surgery is suggested. There is moderate pathology of median nerve at left wrist, status post operation for left carpal tunnel syndrome. The latest progress report dated 10/8/13 states that the patient continues to have pain in the right greater than left wrist. Pain is worse at night with associated numbness and tingling. She states that medications help decrease her pain. She states that she is able to function well with less pain. Her physician is requesting an appeal to a denial for an interferential unit, paraffin unit, and heating pad s/p left carpal tunnel release "so that the patient can transition therapy in care of home for self-rehabbing".

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 Paraffin Wax 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 Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, Section 9792 and page 15, which is part of MTUS.

Rationale for the Decision:

Paraffin wax is considered a passive modality. Passive modalities should be minimized in favor of active treatments. **The request for 1 Paraffin Wax Unit is not medically necessary and appropriate.**

2) Regarding the request for 1 heat pad :

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, Physical Medicine, page 98, which is part of MTUS.

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 (ODG), Carpal Tunnel Syndrome, Heat Therapy.

Rationale for the Decision:

The ODG recommends at-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat therapy. The employee's physician advised the employee to continue physical therapy after left carpal tunnel release surgery transitioning to home care. **The request for 1 heat pad is medically necessary and appropriate.**

3) Regarding the request for 1 interferential 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 Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98, which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), section 9792 and page 15, and the Postsurgical Treatment Guidelines (2009), page 10, which are part of MTUS; and the Official Disability Guidelines (ODG), carpal tunnel syndrome section, which is not part of MTUS.

Rationale for the Decision:

The ODG indicates passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments. An interferential unit is a passive modality. The Postsurgical Treatment Guidelines indicate passive modalities are occasionally useful in the post-surgical physical medicine period, their use should be minimized. **The request for 1 interferential 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

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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.