
Notice of Independent Medical Review Determination

Dated: 10/2/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/9/2013

12/19/2011

7/19/2013

CM13-0002222

- 1) MAXIMUS Federal Services, Inc. has determined the request for TENS unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for hot and cold compression garment **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 12/19/2011 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 TENS unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for hot and cold compression 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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013:

“Clinical History: This patient had an initial date of injury of 12/19/11. The most recent note was from Dr. [REDACTED] on 06/25/13, which was a letter asking for reconsideration of the previously requested EMG, TENS unit, hot and cold pack, and cervical pillow. There was a note dated 05/23/13 that reported that the patient had neck, right shoulder, and right elbow pain. There are complaints of numbness and tingling in the right hand. The patient continues to work full time and does exercise every day. The patient has right elbow pain referred to the 4th and 5th digits due to cubital tunnel syndrome. There is also right rotator cuff inflammation. Appeal is recommended for the hot and cold compression garment, cervical collar with gel and cervical pillow. The patient is currently working full time as a Fire Department Chief.”

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 Independent Medical Review (received 7/19/2013)
- Utilization Review Determination from [REDACTED] (dated 7/9/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for a Tens unit:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), pg. 114-116 which are part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on December 19, 2011 to the neck, right shoulder, and right elbow pain. The medical records provided indicate the diagnosis of cubital tunnel syndrome and right rotator cuff inflammation. Treatments have included physical therapy and home exercises. The request is for a transcutaneous electrical nerve stimulator (TENS) unit.

The MTUS Chronic Pain guidelines indicate that there should be evidence that other appropriate pain modalities have been tried and failed including medication and other ongoing pain treatment. A one-month trial period should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The medical records reviewed do not document a one-month trial period with efficacy of the TENS unit and ongoing treatment during that TENS trial. The request for a TENS unit **is not medically necessary and appropriate.**

2) Regarding the request for Hot and Cold compression garment:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Neck and Upper Back Complaints (ACOEM Practice Guidelines, 2nd Edition, (2004), Chapter 8) Table 8-8, pg. 173-174,181 which are part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on December 19, 2011 to the neck, right shoulder, and right elbow pain. The medical records provided indicate the diagnosis of cubital tunnel syndrome, and right rotator cuff inflammation. Treatments have included physical therapy, home exercises. The request is for hot and cold compression garment.

The MTUS/ACOEM guidelines recommend at-home applications of heat or cold, however, special devices are not recommended. The medical records provided

for review do not indicate a medical necessity for a hot and cold compression garment versus local application of heat or ice. The request for hot and cold compression 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.