
Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	3/15/1998
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004028

- 1) MAXIMUS Federal Services, Inc. has determined the request for 30 day rental of X-Force Stim unit with supplies **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Q-Tech recovery system **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 full leg wrap **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 1 universal therapy wrap **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/7/2013. 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 30 day rental of X-Force Stim unit with supplies **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Q-Tech recovery system **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 1 full leg wrap **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The 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 Preventive Medicine, 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 utilization review determination did not contain a clinical summary.

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
- Utilization Review Determination from [REDACTED]
- Employee medical records from Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request 30 day rental of X-Force Stim unit with supplies:**

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

The Claims Administrator based its decision on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2009) pages 1015, 300, Official Disability Guidelines (ODG) (current version) page 6, which are not part of MTUS, and Chronic Pain Medical Treatment Guidelines (2009) pages 5, 6, 7, 114, 115, 116, 120,

Post-Surgical Treatment Guidelines (2009) which are part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines page 116 of 127, which is a part of MTUS.

Rationale for the Decision:

The MTUS Guidelines state transcutaneous electrotherapy is recommended in those individuals with chronic intractable pain of greater than three months' duration, who have tried and failed other appropriate pain modalities, including analgesic medications. In this case, the records provided for review show no clearly stated evidence of oral analgesic failure on the request for authorization, request for MRI, or attached progress note, which is handwritten and difficult to follow. Furthermore, there is no description of prior successful one month trial of an Xforce stimulator or TENS unit. **The request for 30day rental of X-Force Stim unit with supplies is not medically necessary and appropriate.**

2) Regarding the request for Q-Tech recovery system:

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

The Claims Administrator based its decision on American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2009) pages 1015, 300, Official Disability Guidelines (ODG) (current version) page 6, 17, 20, 12, 13, 11 which are not part of MTUS, and Post-Surgical Treatment Guidelines (2009) which is a part of Medical Treatment Utilization Schedule (MTUS).

The Expert Reviewer based his/her decision on American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 12, table 12-5, which is a part of Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The MTUS/ACOEM Guidelines state about high-tech cooling devices, these are not recommended for delivery of cold therapy for any chronic pain condition. Simple, at-home applications of heat and cold are thought to suffice for delivery of hot/cold therapy. **The request for Q-Tech recovery system is not medically necessary and appropriate.**

3) Regarding the request 1 full leg wrap:

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

The Claims Administrator did not cite any evidence-based guidelines.

The Expert Reviewer based his/her decision on American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 3rd Edition, which is a part of Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The MTUS/ACOEM Guidelines do not recommend the continuous cooling, high-tech cryotherapy device. Simple, at-home applications of heat and cold are thought to suffice for delivery of cold therapy. In this case, the full leg wrap is intended to facilitate delivery of cryotherapy. Since the cryotherapy device itself was not recommended, the wrap is also not recommended. **The request for 1 full leg wrap is not medically necessary and appropriate.**

4) **Regarding the request 1 universal therapy wrap:**

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

The Claims Administrator did not cite any evidence-based guidelines.

The Expert Reviewer based his/her decision on American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 12, which is a part of Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The MTUS/ACOEM Guidelines do not recommend the continuous cooling, high-tech cryotherapy device. Simple, at-home applications of heat and cold will suffice for delivery of hot/cold therapy. In this case, the universal therapy wrap is intended to facilitate delivery of cryotherapy. Since the cryotherapy device itself was not recommended, the wrap is also not recommended. **The request for 1 universal therapy wrap 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.