

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **12/17/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/2/2013
Date of Injury:	10/24/2011
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005574

- 1) MAXIMUS Federal Services, Inc. has determined the request for **rental of a Pro-Stim 5.0 for cervical spine and right shoulder is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/16/2013. 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 **rental of a Pro-Stim 5.0 for cervical spine and right shoulder 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 and is licensed to practice in Connecticut, North Carolina, and Pennsylvania. 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 sustained an injury to the neck and right upper extremity on 10/24/11. The medical records indicated that since the time of injury, there was prior surgery to the right shoulder in the form of a right shoulder arthroscopy with open hemi-arthroplasty performed on 5/24/12. A biceps tenodesis was also performed at the time of operative intervention. Recent medical records indicated a most recent assessment of 7/19/13 demonstrating diminished grip strength and pain with rotational movements of the shoulder. It stated that, due to the patient's ongoing cervical complaint, an MRI scan was recommended. An open facility was used due to the patient's body habitus. It also indicated at that time that continuation of formal physical therapy would be recommended. The treating physician indicated that the patient had recent electrodiagnostic studies of the upper extremities demonstrating bilateral carpal tunnel syndrome and cubital tunnel diagnoses. Further assessment to the shoulder after physical therapy and activity restrictions was not noted. There is no post-operative imaging for review. At present, there is a request for a Pro-Stim 5.0 rental for the patient's cervical spine and right shoulder as further treatment. This had been denied by utilization review citing lack of documented evidence of long term functional benefit from use of the device.

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:

[REDACTED]



1) Regarding the request for rental of a Pro-Stim 5.0 for cervical spine and right shoulder:

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, pages 114-121, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 114-120, which is part of the MTUS.

Rationale for the Decision:

Based on California MTUS Chronic Pain Guidelines, the use of a nerve stimulator device would not be indicated for this employee's cervical spine or right shoulder. Records fail to demonstrate any acute indication for the above device in addition to no indication of recent conservative care or evidence of functional-based restoration program being utilized for the employee's right shoulder and cervical spine. It is also unclear as to the degree of benefit the employee would obtain from the above device given the time frame from surgical process. **The request for rental of a Pro-Stim 5.0 for cervical spine and right shoulder 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.