

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

8/2/2013

6/5/2012

8/12/2013

CM13-0009767

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy two times a week for three weeks for the wrists and left elbow is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **acupuncture therapy two times a week for three weeks for the wrists and left elbow is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **localized intense neurostimulation (LINT) therapy two times a week for three weeks for trigger points on the lumbar spine is not medically necessary and appropriate**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **physical therapy two times a week for three weeks for the wrists and left elbow** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **acupuncture therapy two times a week for three weeks for the wrists and left elbow** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **localized intense neurostimulation (LINT) therapy two times a week for three weeks for trigger points on the lumbar spine** 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 PM & R, 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.

Expert Reviewer Case Summary:

The underlying date of injury in this case is June 5, 2012. Treating diagnoses in this case include carpal tunnel syndrome and lumbosacral sprain. An initial Utilization Review decision states that there was no clear documentation of objective functional deficits and functional goals to support an indication for physical therapy or acupuncture treatment. Additionally, that review noted that the medical guidelines did not support the use of neuromuscular stimulation for this patient's underlying condition.

A narrative letter of June 2, 2013 by primary treating physician Dr. [REDACTED] reviews this patient's history of continuance trauma from September 2011 through June 2012. Dr. [REDACTED] notes the patient's diagnoses of bilateral carpal tunnel syndrome, lumbar spine ligamentous injury, secondary stress and depression and anxiety, and secondary sleep depression. Dr. [REDACTED] referred the patient for orthopedic follow up for possible bilateral carpal tunnel surgery and also recommended extracorporeal shock wave therapy. Dr. [REDACTED] also recommended in-office physical therapy since home therapy had failed and also requested a short course of acupuncture. Dr. [REDACTED] also recommended LINT therapy to stimulate and evaluate the patient's myofascial symptoms.

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 physical therapy two times a week for three weeks for the wrists and left elbow:

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 ACOEM Pain, Suffering and Restoration of Function Chapter, page 114, which is part of the MTUS. The Claims Administrator also based its decision on the Official Disability Guidelines (ODG), which are not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 98, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines section on physical medicine states that active therapy requires an internal effort by the individual to complete a specific exercise or task and to allow for fading of treatment frequency plus active self-directed home physical medicine. The treatment guidelines, therefore, encourage independent home rehabilitation at this time. If supervised, rather than independent rehabilitation, were indicated, the guidelines would require a specific prescription with particular stated methods and goals. The medical records provided for review are not specific regarding the specific methods or goals for proposed physical therapy, which would be particularly important since this employee has failed prior physical therapy. Therefore, there is not sufficient information to support a specific treatment plan for physical therapy. **The request for further physical therapy for the wrists and left elbow is not medically necessary and appropriate.**

2) Regarding the request for acupuncture therapy two times a week for three weeks for the wrists and left elbow:

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 Acupuncture Medical Treatment Guidelines, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Acupuncture Medical Treatment Guidelines, Section 24.1, which is part of the MTUS.

Rationale for the Decision:

The California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation or to hasten functional recovery. The medical records submitted for review are not specific in terms of the functional goals of proposed acupuncture, nor do the records indicate that pain medication has been reduced or not tolerated. Thus, the medical records do not support an indication or goals of acupuncture consistent with the treatment guidelines. **The request for acupuncture therapy for the wrists and left elbow is not medically necessary and appropriate.**

3) Regarding the request for localized intense neurostimulation (LINT) therapy two times a week for three weeks for trigger points on the lumbar spine:

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, which are part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 122, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Medical Treatment Guidelines' section on trigger point injections recommends trigger point injections with a localized anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when specific criteria are met. These guidelines do not recommend LINT therapy for trigger points in the lumbar spine. Moreover, the medical records provided for review provide a general reference in ACOEM Guidelines but not a specific reference regarding indications for LINT therapy. LINT therapy is an investigational/experimental treatment not supported in the treatment guidelines. **The request for LINT therapy for trigger points on the lumbar spine 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

/dso

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.