

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/7/2013
Date of Injury:	10/14/2011
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010658

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **trancutaneous electrical nerve stimulator (TENS) unit is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 8/7/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 **physical therapy** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **trancutaneous electrical nerve stimulator (TENS) 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 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:

This patient's underlying date of injury is October 14, 2011 with the treating diagnosis of chronic pain in the neck and arms as well as diffuse right shoulder and arm pain due to thoracic outlet syndrome. The patient additionally has a history of cervical fusion surgery in 2000 and in 2006 as well as chronic right shoulder pain with supraspinatus tendinitis. A prior review in this case of August 7, 2013 notes that medical records indicate that the patient had achieved a plateau in physical therapy. That prior review also notes that the medical records did not document a TENS trial with analgesic or functional improvement. The record contains a prescription of August 1, 2013 requesting a physical therapy evaluation and treatment and also requests home TENS unit with a diagnosis of right shoulder pain and thoracic outlet syndrome.

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:

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 Chapter 9, Algorithms 9-4 & 9-5, which is part of the MTUS, and the Official Disability Guidelines (ODG), Shoulder chapter, Physical Therapy, which is not part of the MTUS

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

Rationale for the Decision:

The MTUS Chronic Pain 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 medical records provided for review outline an evaluation/treatment prescription but do not outline a specific prescription by the treating physician during the time period under review. The employee would be anticipated to have transitioned to independent home rehabilitation given the chronicity in this case. The medical records do not provide a rationale for supervised rather than independent therapy during the time frame under review. Therefore, the treatment guidelines and records indicate that the requested treatment was not medically necessary. **The request for physical therapy is not medically necessary and appropriate.**

2) Regarding the request for a transcutaneous electrical nerve stimulator (TENS) 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, page 114-117, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS/Chronic Pain, page 114, which is a part of MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines' section on TENS/chronic pain, indicate that it is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The medical records provided for review do not outline results of a one-month home-based TENS trial as part of an overall evidence-based functional restorative program. Thus, the medical records do not provide an indication for the requested TENS unit consistent with the treatment guidelines. **The request for a transcutaneous TENS 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

/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.