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**Notice of Independent Medical Review Determination**

Dated: 11/1/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/15/2013

9/27/2009

7/26/2013

CM13-0003679

- 1) MAXIMUS Federal Services, Inc. has determined the request for one (1) TENS unit, left shoulder **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for (1) TENS electrodes **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Ultram 50mg #120 **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for one (1) follow up **is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 one (1) TENS unit, left shoulder **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for (1) TENS electrodes **is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for Ultram 50mg #120 **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for one (1) follow up **is 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 and 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 15, 2013

**CLINICAL SUMMARY:** [REDACTED] is a 58 year old injured worker, who sustained an industrial injury on 9/27/09. Left shoulder and upper back are the accepted body parts on this claim. Diagnosis: Status post left shoulder arthroscopic surgery, performed by Dr. [REDACTED] on May 13, 2011, involving rotator cuff repair, subacromial decompression, distal clavicle excision. Extensive debridement of the superior labrum degenerative type I slap tear with post-operative residuals including periscapular myofascial strain.

### 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 (dated 7/26/13)
- Utilization Review Determination from [REDACTED] (dated 7/15/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for one (1) TENS unit, left shoulder:**

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), transcutaneous electrotherapy, pgs.114-115, which is 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 9/27/09. The medical records provided for review indicate treatments have included prescriptive medications, chiropractic rehabilitative therapy, acupuncture, and self-guided home exercise program in conjunction with utilization of a TENS unit. The request is for one (1) TENS unit, left shoulder.

MTUS Guidelines 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. According to the medical records provided for review the employee reported using the TENS unit at a frequency of 2 times per week for 25 minutes duration and it is helpful. The employee had a gradual and progressive improvement of their condition back to baseline. The records show that the employee has a TENS unit at home. No discussion was noted to indicate that the employee needed a new unit. The request for one (1) TENS unit, left shoulder is not medically necessary and appropriate.

**2) Regarding the request for (1) TENS electrodes:**

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), transcutaneous electrotherapy, pgs.114-116, which is 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 9/27/09. The medical records provided for review indicate treatments have included prescriptive medications, chiropractic rehabilitative therapy, acupuncture, and self-guided home exercise program in conjunction with utilization of a TENS unit. The request is for (1) TENS electrodes.

MTUS/ Chronic Pain Medical Treatment Guidelines indicate that TENS electrodes are 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. According to the medical records provided for review the employee reported using the TENS unit at a frequency of 2 times per week for 25 minutes duration and it is helpful. The employee had a gradual and progressive improvement of their condition back to baseline. Replacement electrodes are reasonable. The request for (1) TENS electrodes is medically necessary and appropriate.

### **3) Regarding the request for Ultram 50mg #120:**

#### 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), Tramadol (Ultram), pg. 89, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), Tramadol, pg 82, Pain Outcomes and Endpoints pages 8, 11, and 82, which are part of MTUS.

#### Rationale for the Decision:

The employee sustained a work-related injury on 9/27/09. The medical records provided for review indicate treatments have included prescriptive medications, chiropractic rehabilitative therapy, acupuncture, and self-guided home exercise program in conjunction with utilization of a TENS unit. The request is for Ultram 50mg #120.

MTUS Guidelines indicate that Opioids for neuropathic pain are not recommended as a first-line therapy. Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). According to the medical records provided for review the employee has a satisfactory response to pain medication with a decrease in his chronic pain from a 5/10 to 1-2/10. The request for Ultram 50mg #120 is medically necessary and appropriate.

### **4) Regarding the request for one (1) follow up:**

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Hip, Office Visits, which is not a part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 11 and 8, Pain Outcomes and Endpoints, which are part of MTUS.

#### Rationale for the Decision:

The employee sustained a work-related injury on 9/27/09. The medical records provided for review indicate treatments have included prescriptive medications,

chiropractic rehabilitative therapy, acupuncture, and self-guided home exercise program in conjunction with utilization of a TENS unit. The request is for one (1) follow up.

MTUS/Chronic Pain Medical Treatment Guidelines indicate that treatment shall be provided as long as the pain persists beyond the anticipated time of healing and throughout the duration of the chronic pain condition. Furthermore subjective reports of pain severity may not correlate well with its functional impact. Thus, it is essential to understand the extent that function is impeded by pain when prescribing controlled substances for pain, satisfactory response to treatment may be indicated by the employee's decreased pain, increased level of function, or improved quality of life. According to the medical records provided for review, the employee has chronic pain that require follow up visits for medication management due to his residual pain and potential flare-ups. The request for one (1) follow up is 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, 18<sup>th</sup> 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.