

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/20/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	11/5/2010
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0005512

- 1) MAXIMUS Federal Services, Inc. has determined the request for **occupational therapy to the right elbow is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **epicondylar release (L), radial tunnel release (L) is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **postop physical therapy eight (8) sessions to the left elbow is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy for postop, left elbow 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 7/12/2013. 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 **occupational therapy to the right elbow is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **epicondylar release (L), radial tunnel release (L) is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **postop physical therapy eight (8) sessions to the left elbow is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy for postop, left elbow 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 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.

Expert Reviewer Case Summary:

The patient is a 51-year-old female who reported injury on 11/5/2010. Supplied documentation includes a Utilization Review Determination dated 7/8/2013 regarding Additional physical therapy and an orthopedic re-evaluation. In the determination it was stated the patient did not receive physical therapy until 4 months after her surgery. There is also a recommendation for 4 sessions of physical therapy.

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 Treatment Utilization Schedule (MTUS)

1) Regarding the request for occupational therapy to the right 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 Postsurgical Medical Treatment Guidelines, Physical Medicine Section, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Post-Surgical Treatment Guidelines, pgs. 10, 17, Lateral epicondylitis/Tennis elbow, which is part of the MTUS.

Rationale for the Decision:

Post-Surgical Treatment Guidelines recommend post-surgical treatment for lateral epicondylitis for 12 visits over 12 weeks, and that in order to continue physical therapy the patient must have clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical examination. Clinical documentation submitted for review, as per the date of 07/25/2013, indicated the employee had full range of motion with pain at the end range. It failed to provide that the employee had made functional improvement with prior treatment, fails to provide the number of sessions the employee has had and fails to provide the continuation of occupational therapy as the employee's surgery was noted to be 11/08/2012.

The request for occupational therapy to the right elbow is not medically necessary and appropriate.

2) Regarding the request for epicondylar release (L), radial tunnel release (L):

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 Postsurgical Medical Treatment Guidelines, Physical Medicine Section, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Elbow Disorders, Chapter 10, pg. 45, which is part of the MTUS.

Rationale for the Decision:

ACOEM Guidelines recommend conservative care for 3 to 6 months and indicate that there are no published randomized control trials (RCTs) that indicate surgery improves the condition over non-surgical options. Additionally, it states that surgery for radial nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence, including positive electrical studies that correlate with clinical findings. Clinical documentation submitted for review fails to indicate the employee had positive electrical studies, fails to provide the employee had an adequate trial of conservative care, and fails to provide a recent thorough physical examination with objective findings indicative of lateral epicondylalgia and the necessity for a radial tunnel release. **The request for epicondylar release (L), radial tunnel release (L) is not medically necessary and appropriate.**

3) Regarding the request for postop physical therapy eight (8) sessions to the 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 Postsurgical Medical Treatment Guidelines, Physical Medicine Section, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, pgs. 10 & 17, Lateral epicondylitis/Tennis elbow, which is part of the MTUS.

Rationale for the Decision:

The Postsurgical guidelines recommend 12 visits over 12 weeks for lateral epicondylitis. Additionally, it recommends an initial course of therapy, meaning half of the number of visits specified in the general course of therapy for the specific surgery. Since the primary procedure is not medically necessary, all the associated services, including postop physical therapy 8 sessions, are not medically necessary. **The request for postop physical therapy eight sessions to left elbow is not medically necessary and appropriate.**

4) Regarding the request for cold therapy for postop, 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 Postsurgical Medical Treatment Guidelines, Physical Medicine Section, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Elbow Disorders, pgs. 27-28, which is part of the MTUS.

Rationale for the Decision:

ACOEM Guidelines recommend at-home local applications of cold packs during the first few days of acute symptoms; thereafter, application of heat packs or cold packs as the patient prefers. Since the primary procedure is not medically necessary, all the associated services, including cold therapy, are not medically necessary. **The request for cold therapy for postop, left elbow 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

/ldh

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.