

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/6/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	12/14/2004
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006582

- 1) MAXIMUS Federal Services, Inc. has determined the request for ortho consult and replace TENS unit for right finger **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/29/2013. 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 ortho consult and replace TENS unit for right finger **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 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.

Expert Reviewer Case Summary:

This patient is a 52-year-old male who reported an injury on 12/14/2004. The patient was seen by Dr. [REDACTED] on 01/30/2013. Objective findings included tenderness noted over the right biceps, left upper arm, and lateral epicondyle area. Diagnoses at that time included carpal tunnel syndrome, lesion of the ulnar nerve, and forearm joint pain. The treatment plan included continuation of current medications. The patient was then seen by an unknown physician on 01/30/2013 and 03/13/2013. The patient continued to complain of pain in the left elbow, and left hand and first 2 fingers. Objective findings included tenderness to palpation of the lateral epicondyle area and the left upper extremity. Diagnoses included carpal tunnel syndrome, lesion of the ulnar nerve, and forearm joint pain. The treatment plan included continuation of current medications. The patient followed up with Dr. [REDACTED] on 04/17/2013. It is noted that the patient continued to have pain in the same areas with increased pain in the right biceps and hands. Objective findings included tenderness over the right biceps area. The hand and elbow areas remained unchanged. Diagnoses remained the same. The treatment plan included continuation of medications and a return visit to the clinic. A peer review report was submitted on 07/25/2013 by Dr. [REDACTED]. The request included an orthopedic consultation and a replacement TENS unit for the right finger. Each request was determined to be non-certified at that time.

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 [REDACTED]
- Medical Records from Provider

- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for ortho consult and replace TENS unit for right finger:

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 (2009), Pgs. 115-117 of 127, which is a part of MTUS.

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines (2009), Pgs. 114-117 of 127, which is a part of MTUS, and Cornerstones of Disability Prevention and Management (ACOEM (American College of Occupational and Environmental Medicine) Practice Guidelines, 2nd Edition (2004), Chapter 5, pgs 270-271, which is a part of MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines state referral for hand surgery consultation may be indicated for patients who have red flags of a serious nature, fail to respond to conservative management, including worksite modifications and have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. As for the clinical notes submitted, there is no indication that orthopedic intervention is necessary for this employee. There is no documentation of a failure to respond to conservative management, or significant deficits requiring surgical intervention. MTUS Guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There should be documentation of pain of at least 3 months in duration and evidence that other appropriate pain modalities have been tried and failed prior to the use of a TENS unit. There is no documentation submitted for review that provides evidence of chronic intractable pain lasting longer than 3 months in duration, nor is there evidence that other appropriate pain modalities have been tried and failed for this employee. There is no documentation submitted that provides any evidence of this employee's previous use of a TENS unit with documented efficacy and objective functional gains. **The request for an orthopedic consultation and replacement TENS unit for the right finger 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

/hs

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.