

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	4/16/2013
Date of Injury:	4/23/2012
IMR Application Received:	8/9/2013
MAXIMUS Case Number:	CM13-0009398

- 1) MAXIMUS Federal Services, Inc. has determined the request for **IF Stim unit for 3-6 months for right shoulder pain is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/9/2013 disputing the Utilization Review Denial dated 4/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **IF Stim unit for 3-6 months for right shoulder pain 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. 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 claimant is a 60-year-old gentleman who was injured April 23, 2012 sustaining injury to the right shoulder. Clinical records for review include understanding of initial injury of the right shoulder, cervical pain, elbow pain and wrist pain to the right upper extremity. Records indicate the claimant has utilized a TENS unit, work restrictions, medication management and a course of formal physical therapy with no significant benefit. Prior imaging to the right shoulder consists of a February 4, 2013 MRI report that showed tendinopathy and fraying of the bursal surface with intrasubstance tearing to the supraspinatus tendon. The last documentation of physical examination findings is from January 2013, a comprehensive orthopedic evaluation showing the right shoulder to be with 150 degrees of forward flexion, 90 degrees of external rotation, 5/5 motor tone and strength, tenderness over the AC joint, positive Neer and Hawkins test. Assessment on that date was of continued bilateral upper extremity and cervical pain as a result of "continuous trauma". At present there is a request for a three to six month rental of an interferential stimulator unit to the right shoulder for further use. Request was denied by Utilization Review on April 16, 2013 citing lack of supportive evidence of long term lasting pain relief or benefit of the device for the claimant's current condition.

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)
- Medical Records from the Claims Administrator

1) Regarding the request for IF Stim unit for 3-6 months for right shoulder pain:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Guidelines, Interferential Current Stimulation, page 118 and page 120, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Chronic Pain Guidelines do not recommend interferential stimulator units as an isolated intervention. The role of this device in the employee's chronic setting would not be indicated and is not in accordance with guideline recommendations. **The request for IF Stim unit for 3-6 months for right shoulder pain 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

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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.