

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination.

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- 1) MAXIMUS Federal Services, Inc. has determined the transcutaneous electrical joint stimulation device system requested is **not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on April 3, 2013 disputing the Utilization Review Denial dated March 15, 2013. A Notice of Assignment and Request for Information was provided to the above parties on April 10, 2013. A decision has been made for the treatment in dispute.

- 1) MAXIMUS Federal Services, Inc. has determined the transcutaneous electrical joint stimulation device system requested is not medically necessary and appropriate.

Medical Qualifications of the Professional 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, has a subspecialty certificate in Pain Medicine, 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 professional 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 March 15, 2013.

“The patient is a 32-year-old female with history of a work related injury on 2/14/13. The office report from 2/18/13 indicates the patient fell down stairs with injuries to the shoulder, back, knees, and ribs. The patient had bruising and contusions. The patient was prescribed medications and physical therapy. It appears that she was seen again on 3/7/13 with complaints of neck and shoulder pain. The patient was prescribed an interferential stimulator. EXPLANATION OF FINDINGS: The documentation indicates that the patient had a fall with multiple areas of discomfort. She was noted to have bruises and contusions. The California MTUS Guidelines, page 118 notes ‘Interferential Current Stimulation (ICS): Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone.’ There is no indication that this patient has had a trial of therapy. There is no indication this patient has had a trial of a standard stimulator. Based on the above, medical necessity is not established by the documentation or by guidelines for the prescribed interferential stimulator.”

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
- Utilization Review [REDACTED] (dated 3/15/13)
- Medical Review by [REDACTED] (dated 3/14/13)
- Request for Medical Authorization (dated 3/7/13)
- Chronic Pain Treatment Guidelines (2009) – Pages 118-121
- Employee's Medical Records from [REDACTED] Inc. (dated 2/18/13 through 4/3/13)
- Employee's Medical Records from [REDACTED] (dated 2/14/13 and 2/18/13)
- Employee's Medical Records from [REDACTED] (dated 3/14/13 and 3/20/13)
- Employee's Medical Records from [REDACTED] (dated 4/3/13 through 4/17/13)

1) Regarding the Request for transcutaneous electrical joint stimulation device system:

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

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines (2009) pages 118 - 121, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the referenced section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision

The patient fell down stairs with injuries to the shoulder, back, knees, and ribs on 2/14/13. The patient was prescribed medications and physical therapy. The patient was seen again on 3/7/13 with neck and shoulder pain. The patient was prescribed a transcutaneous electrical joint stimulation device system (referenced in the guidelines as an "interferential stimulator"). The Chronic Pain Treatment Guidelines state that Interferential Stimulation Therapy is not recommended as an isolated intervention. Possible clinical conditions in which Interferential Stimulation is indicated per the Guidelines include when:

- Pain is ineffectively controlled due to diminished effectiveness of medications;
- Pain is ineffectively controlled with medications due to side effects;
- History of substance abuse;
- Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or
- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.).

The medical records provided lack documentation of any of the above conditions or circumstances. The transcutaneous electrical joint stimulation device system is not medically necessary.

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;

Richard C. Weiss, MD, MPH, MMM, PMP
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.