

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested MRI Lumbar spine **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Electronic Muscle Stimulator Unit **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/13/2013 disputing the Utilization Review Denial dated 5/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/14/2013. 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 requested MRI Lumbar spine **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Electronic Muscle Stimulator Unit **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 28, 2013

“Cit with low back pain after heavy lifting on 1/28/13. Per note dated 5/6/13 by Dr. [REDACTED] Cit complained of pain in the neck and low back and LT LE. Exam of 5/6/13 revealed cervical and lumbar tenderness and LOM. Strength in the Les was normal but sensation was decreased “over the lateral aspect of the left calf extending over the top of the foot in all toes”.”

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 (received 6/13/13)
- Utilization Review determination from [REDACTED] (dated 5/28/13)
- Employee medical records from [REDACTED] MD (dated 5/6/13)
- Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 303-309
- Chronic Pain Medical Treatment Guidelines (May, 2009), Part 2, Pain Interventions and Treatments, pg. 104-106

1) Regarding the request for MRI Lumbar spine:

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

The Claims Administrator based its decision on the ACOEM Treatment Guidelines (latest edition), Chapter 9, Low Back Disorders, which is not 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 Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, Special Studies and Diagnostic Treatment Considerations, pg. 303-305 which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related low back injury after heavy lifting on 1/28/13. Medical records provided and reviewed indicate treatment has consisted of oral medications and physical therapy. The medical record of 5/6/13 shows the employee continues to have pain with focal tenderness over the left sacroiliac, right gluteal region, and lower lumbosacral paraspinal muscles, as well as decreased range of motion and decreased sensation over the lateral aspect of the left lower extremity.

ACOEM MTUS supports the use of MRI imaging when there is evidence of neurological deficits and conservative treatment has failed. The employee is now almost six months post injury, meeting the criteria for failed conservative treatment. The Lumbar Spine MRI **is medically necessary and appropriate.**

2) Regarding the request for Electronic Muscle Stimulator Unit :

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, Section: Pain, which is not 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, Transcutaneous Electrotherapy, pg. 114, which is part of the Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee sustained a work-related low back injury after heavy lifting on 1/28/13. Medical records provided and reviewed indicate treatment has consisted of oral medications and physical therapy. The medical record of 5/6/13 shows the employee continues to have pain with focal tenderness over the left sacroiliac, right gluteal region, and lower lumbosacral paraspinal muscles, as well as decreased range of motion and decreased sensation over the lateral aspect of

the left lower extremity. The employee is now almost six months post injury, and has failed conservative treatment, meeting the criteria for chronic pain.

The Chronic Pain Medical Treatment Guidelines do not support the use of electrical muscle stimulators as there are no high quality, evidence-based guidelines or randomized controlled trials showing statistical significance for use. The Electronic Muscle Stimulator Unit **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;

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.