

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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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 request for 3 localized intense neurostimulation sessions for the thoracic and lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 6 acupuncture therapy sessions **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/24/2013 disputing the Utilization Review Denial dated 6/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/25/2013. 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 3 localized intense neurostimulation sessions for the thoracic and lumbar spine **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 6 acupuncture therapy sessions **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 Rehabilitations 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 June 17, 2013.

The patient is a 63-year-old male who sustained injury on 1/16/2013 after carrying a heavy box. He is currently diagnosed with lumbar and thoracic sprain, lumbosacral neuritis, and myalgia. A request was made for six acupuncture sessions. The submitted reports showed the patient attending six visits of chiropractic treatment from 2/6/13 to 2/22/13 and had slow improvement. A lumbar MRI on 2/21/13 by [REDACTED] MD showed multiple degenerative disc disease, mild to moderate central stenoses at L1-2, L2-3, and L3-4, and multilevel neuroforaminal stenoses. On 6/4/13, he presented with frequent lower back pain traveling to the left leg with numbness and tingling. He is noted to be attending PT, aquatherapy, and acupuncture. The physical examination showed normal sensation, normal motor strength, and normal reflexes.

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 Determinations by [REDACTED] (dated 6/17/13)
- Utilization Review Recommendations by [REDACTED] (dated 6/14/13)
- Doctor's First Report of Injury and Progress Reports (dated 1/17/13 to 2/22/13)
- Employee's Medical Records by [REDACTED] (dated 4/23/13)

- Employee's Medical Records by [REDACTED] M.D. (dated 4/9/13 to 5/16/13)
- Employee's Medical Records by [REDACTED] (dated 3/1/13 to 6/4/13)
- Employee's Diagnostic Reports by [REDACTED] (dated 3/22/13 to 3/24/13)
- Acupuncture Medical Treatment Guidelines (2009)
- Gorenberg M, Schiff E, Schwartz K, and Eizenberg E. A Novel Image-Guided, Automatic, High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain. Pain Research and Treatment, vol. 2011, Article ID 152307, 6 pages, 2011. doi:10.1155/2011/152307

1) Regarding the request for 3 localized intense neurostimulation sessions for the thoracic and lumbar spine:

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

The Claims Administrator based its decision on Gorenberg M, Schiff E, Schwartz K, and Eizenberg E. A Novel Image-Guided, Automatic, High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain. Pain Research and Treatment, vol. 2011, Article ID 152307, 6 pages, 2011. doi:10.1155/2011/152307, which is a medical journal article that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronis Pain Medical Treatment Guidelines (2009) (page 120), which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 1/16/2013 and experienced chronic low and mid back pain, which radiates to the left leg. The employee's medical records received and reviewed show treatment to date has included: analgesic medications; care from various providers in various specialities; imaging studies; physical therapy, aquatic therapy, acupuncture, localized intensive neurostimulation therapy (LINT); and extensive periods of time off of work. A request was submitted for 3 localized intense neurostimulation sessions for the thoracic and lumbar spine.

Based on the description of the service, the requested treatment appears to represent a form of microcurrent electrical stimulation (MENS). The employee's pain appears to be chronic, as there is no documentation of functional improvement despite the various treatments already received. The Chronic Pain Medical Treatment Guidelines do not recommend MENS for treatment of chronic pain. The request for 3 localized intense neurostimulation sessions for the thoracic and lumbar spine is not medically necessary and appropriate.

2) Regarding the request for 6 acupuncture therapy sessions:

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

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines (2009), which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 1/16/2013 and experienced chronic low and mid back pain, which radiates to the left leg. The employee's medical records received and reviewed show treatment to date has included: analgesic medications; care from various providers in various specialties; imaging studies; physical therapy, aquatic therapy, acupuncture, localized intensive neurostimulation therapy (LINT); and extensive periods of time off of work. A request was submitted for 6 additional acupuncture sessions.

The employee has had prior unspecified amounts of acupuncture. The Acupuncture Medical Treatment Guidelines indicate acupuncture can be extended if there is evidence of functional improvement. In this case, there is no documentation of any functional improvement to date. The employee has failed to return to work and the employee's work status appears to have worsened from visit to visit. The request for 6 acupuncture sessions 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.