MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/20/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/5/2013
Date of Injury:	9/7/2007
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010422

1) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 2 lead wires, per pair is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 8 electrodes, per pair is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 12 replacement batteries is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 16 adhesive remover wipes is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/13/2013 disputing the Utilization Review Denial dated 8/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 **Retrospective request for 2 lead wires, per pair** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 8 electrodes, per pair** is not **medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 12 replacement batteries** is not **medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the **Retrospective request for 16 adhesive remover wipes** 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 & Rehabilitation, has a subspecialty in Interventional Spine 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:
Limited records are available for this IMR. The IMR application shows the patient has a cumulative trauma injury from 2006-2007 and is disputing the 8/5/13 UR decision. The 8/5/13 UR decision was a conditional denial for leads, electrodes, batteries and adhesive removal. UR states they did not receive a response to their request for additional information before the decision timeframe. There is a note from [redacted] dated 9/27/13 stating the [redacted] provided either an interferential or TENS unit to the patient on a self-procured basis, and that the case was settled on 9/7/2008, based on the AME from Dr [redacted] dated 8/25/08. The 8/25/08 report was the only report available for IMR. On 8/25/08, the patient was 55 YO, RHD, F, [redacted] representative. she had pain in the right shoulder and arm. Diagnosis was right shoulder adhesive capsulitis and impingement and cervical DDD. Future medical did not discuss TENS or interferential.

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 Records from Claims Administrator

- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding Retrospective request for 2 lead wires, per pair:**

The Medical Treatment Guidelines 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 Treatment Guidelines, Transcutaneous electrotherapy, pages 114-121 which is part of the MTUS, and the Official Disibility Guidelines (ODG), Transcutaneous Electrical Nerve Stimualtion, and Interferential Current Stimulation (ICS), which is not part of the MTUS.

Rationale for the Decision:
Limited information is available for IMR. The application shows the treating physician as [redacted], MD, but there are no medical reports from Dr [redacted] The Claims Administrator (CA) states the Interferential unit and/or TENS was provided by VQ Orthocare on a self-procured basis. There are no records from VQ Orthocare. The CA states the case was settled in 2008 based on an 8/25/08 Agreed Medical Exam (AME) report, which was provided, but does not discuss future medical for any e-stim device. The submitted records do not contain any reporting or description as to what electrical device the leads, electrodes, or batteries are for. I will apply the MTUS guidelines for interferential and TENS, as this is what the CA mentioned were provided to the patient.

MTUS Chronic Pain Guidelines indicate that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The MTUS for Interferential states: “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 the employee meets the criteria for TENS or Interferential. There is no discussion from the treating physician regarding a program of functional restoration, no mention of whether the treatment is to be a primary treatment modality or in conjunction with other treatment. There is not enough information provided to confirm that the unspecified electrical unit is provided in accordance with MTUS guidelines, and since “medical necessity” has been defined as treatment based on MTUS guidelines, use of the electrical unit cannot be considered medically necessary. If the unspecified electrical unit is not medically necessary, the accessories for the electrical unit including the leads, pads, batteries and pad adhesive remover would not be necessary. **The retrospective request for 2 lead wires, per pair is not medically necessary and appropriate.**

2) **Regarding the Retrospective request for 8 electrodes, per pair:**

The Medical Treatment Guidelines 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 Treatment Guidelines, Transcutaneous electrotherapy, pages 114-121 which is part of the MTUS, and the Official Disibility Guidelines (ODG), Transcutaneous Electrical Nerve Stimualtion, and Interferential Current Stimulation (ICS), which is not part of the MTUS.

Rationale for the Decision:
MTUS Chronic Pain Guidelines indicate that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The MTUS for Interferential states: "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 the employee meets the criteria for TENS or Interferential. There is no discussion from the treating physician regarding a program of functional restoration, no mention of whether the treatment is to be a primary treatment modality or in conjunction with other treatment. There is not enough information provided to confirm that the unspecified electrical unit is provided in accordance with MTUS guidelines, and since "medical necessity" has been defined as treatment based on MTUS guidelines, use of the electrical unit cannot be considered medically necessary. If the unspecified electrical unit is not medically necessary, the accessories for the electrical unit including the leads, pads, batteries and pad adhesive remover would not be necessary. **The retrospective request for 8 electrodes, per pair is not medically necessary and appropriate.**

3) **Regarding the Retrospective request for 12 replacement batteries:**

The Medical Treatment Guidelines 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 Treatment Guidelines, Transcutaneous electrotherapy, pages 114-121 which is part of the MTUS, and the Official Disibility Guidelines (ODG), Transcutaneous Electrical Nerve Stimualtion, and Interferential Current Stimulation (ICS), which is not part of the MTUS.

Rationale for the Decision:
MTUS Chronic Pain Guidelines indicate that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The MTUS for Interferential

states: “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 the employee meets the criteria for TENS or Interferential. There is no discussion from the treating physician regarding a program of functional restoration, no mention of whether the treatment is to be a primary treatment modality or in conjunction with other treatment. There is not enough information provided to confirm that the unspecified electrical unit is provided in accordance with MTUS guidelines, and since “medical necessity” has been defined as treatment based on MTUS guidelines, use of the electrical unit cannot be considered medically necessary. If the unspecified electrical unit is not medically necessary, the accessories for the electrical unit including the leads, pads, batteries and pad adhesive remover would not be necessary. **The retrospective request for 12 replacement batteries is not medically necessary and appropriate.**

4) **Regarding the Retrospective request for 16 adhesive remover wipes:**

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 Treatment Guidelines, Transcutaneous electrotherapy, pages 114-121 which is part of the MTUS, and the Official Disibility Guidelines (ODG), Transcutaneous Electrical Nerve Stimualtion, and Interferential Current Stimulation (ICS), which is not part of the MTUS.

Rationale for the Decision:
MTUS Chronic Pain Guidelines indicate that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The MTUS for Interferential states: “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 the employee meets the criteria for TENS or Interferential. There is no discussion from the treating physician regarding a program of functional restoration, no mention of whether the treatment is to be a primary treatment modality or in conjunction with other treatment. There is not enough information provided to confirm that the unspecified electrical unit is provided in accordance with MTUS guidelines, and since “medical necessity” has been defined as treatment based on MTUS guidelines, use of the electrical unit cannot be considered medically necessary. If the unspecified electrical unit is not medically necessary, the accessories for the electrical unit including the leads, pads, batteries and pad adhesive remover would not be necessary. **The retrospective request for 16 adhesive remover wipes 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.