
Notice of Independent Medical Review Determination

Dated: **12/12/2013**

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/16/2013
Date of Injury: 6/19/2006
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011901

- 1) MAXIMUS Federal Services, Inc. has determined the request for **replacement lumbar conductive garment is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **mist spray is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **power packs is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **shipping and handling is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **TT & SS leadwires is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 **replacement lumbar conductive garment is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **mist spray is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **power packs is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **shipping and handling is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **TT & SS leadwires 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 & Rehab, has a subspecialty 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 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:

This claimant is a 60-year-old male with reported date of injury of 06/19/2006. The mechanism of injury was described as servicing a machine that weighed approximately 100 pounds and he had to lift the machine and in doing so he felt an initial pain to his neck and mid back. He was seen on 07/16/2012 at which time he had complaints of depression, anxiety, and chronic physical pain with physical incapacitation, sleep disturbances, weight gain, fatigue and headaches. Objectively, he had somatic preoccupation, irritability, anger, and anxiety as well. Individual psychotherapy was recommended and had been provided previously. On 06/25/2013, he was seen back in clinic with examination limited to his lumbar spine. Seated straight leg raise and supine straight leg raise produced low back pain only, there was a radiating component when right-sided straight leg raise occurred extending to the left lower extremity in an L5-S1 distribution. Motor testing revealed 4/5 weakness in dorsiflexion and plantar flexion and sensation was intact to the right lower extremity, sensation remained decreased in the left lower extremity in an L5-S1 nerve root distribution. He ambulated in a guarded manner with a shortened stride length and limp. Diagnoses include lumbosacral sprain and strain, status C2 through C6 laminectomy, bilateral foraminotomy and medial

facetomy with arthrodesis, thoracic spine sprain and strain, and right shoulder bursitis, tendinitis, and impingement. He also has insomnia disorder and major depressive disorder as well as gastrointestinal distress secondary to prescription medication. Authorization was requested at that time for replacement of his back conductive garment given his reported benefit in the management of his spasms with inability to perform a home exercise program. Treatment plan includes replacement of his lumbar conductive garment, a mist spray, power packs, and shipping and handling as well as TT and SS leadwires.

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:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for replacement lumbar conductive garment:

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

The Claims Administrator based its decision on the ODG: Pain, criterias for the use of TENS, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Transcutaneous Nerve Stimulation (TENS), page 116, which is a part of MTUS.

Rationale for the Decision:

My rationale for why the requested treatment, replacement lumbar conductive garment is not medically necessary is that the submitted medical records indicate that he had a conductive garment previously. This is designed specifically for a TENS unit. MTUS Guidelines in discussing TENS unit indicates that there should be evidence that other appropriate pain modalities have been tried and failed including medications and 1 trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documented how often the unit was used as well as outcomes in terms of pain relief in function. Rental is preferred over purchase during that trial. Additionally, other ongoing pain treatment should be also during the trial period including medication use per MTUS Guidelines and a treatment plan, including specific short and long-term goals of treatment with a TENS unit should be submitted. The submitted medical records indicate the employee has used a TENS unit with conductive garment in the past and states subjectively the inability to control muscle spasms and perform home exercise program with

that device. However, the records do not include documentation of short and long-term goals of treatment with use of TENS units. The records also do not indicate that the employee is engaged in ongoing treatment with a functional restoration approach and there was lack of documentation of how often this unit was used as well as lack of documentation of outcomes in terms of pain relief and function. MTUS Guidelines go further indicating that a form-fitting TENS device is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment. There should also be documentation that the employee has medical conditions such as a skin pathology that prevents the use of the traditional system or the TENS unit is to be used under a cast as in treatment for disuse atrophy. The records do not indicate this employee has medical condition such as a skin pathology that prevents the use of the traditional system. Records do not indicate overall efficacy of this device and the records do not indicate a treatment plan for both the short and long-term goals. **The request for replacement lumbar conductive garment is not medically necessary and appropriate.**

2) Regarding the request for mist spray:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) Regarding the request for power packs:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4) Regarding the request for shipping and handling:

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

5) Regarding the request for TT & SS leadwires:

Since the primary procedure is not medically necessary, none of the associated services are 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sce

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.