

Notice of Independent Medical Review Determination

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/14/2013
Date of Injury: 5/30/2013
IMR Application Received: 8/26/2013
MAXIMUS Case Number: CM13-0016125

- 1) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic treatment with exercises and modalities; three times a week for four weeks for a total of twelve visits is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **OrthoStim, EOC1, EOC2; purchase and supplies is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/14/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **chiropractic treatment with exercises and modalities; three times a week for four weeks for a total of twelve visits is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **OrthoStim, EOC1, EOC2; purchase and supplies is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Expert Reviewer who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Chiropractor, has a subspecialty in Musculoskeletal Disorders and Neuromuscular Disorders 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:

According to the available medical records, this is a 51-year-old patient with left shoulder pain, neck pain and lower back pain, date of injury 05/30/2013. X-rays of the cervical is normal, X-rays of the lumbar revealed degeneration and L5-S1 vacuum disc, X-rays of the right shoulder is normal. Previous treatments include chiropractic, acupuncture, physical therapy, medications, injection, cervical pillow, electrical stim, lumbar support and cold/hot pack. PR-2 report dated 10/07/2013 by Dr. Daniel Pavedoff noted patient symptoms unchanged from last visit, shoulder depression test is positive with radiating pain in right upper extremity with tingling on fingertips, right shoulder tender to palpation, right suboccipital spasm, patient to returned to modified work.

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 the request for chiropractic treatment with exercises and modalities; three times a week for four weeks for a total of twelve visits:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy & Manipulation, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation, pages 58-59, which is part of the MTUS.

Rationale for the Decision:

According to the MTUS Chronic Pain Guidelines, the treatment parameters for this employee's surgery is 4 to 6 treatments, 1 to 2 times per week for the first week, and one treatment per week over the next 6 weeks. The medical records provided show that the employee had at least 6 chiropractic treatments completed. However, there is no evidence of objective functional improvement documented. The requested 12 treatments exceed the guidelines recommendations without evidence of objective functional improvement. **The request for chiropractic treatment with exercises and modalities; three times a week for four weeks for a total of twelve visits is not medically necessary and appropriate.**

2) Regarding the request for OrthoStim, EOC1, EOC2; purchase and supplies:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation, which is part of the MTUS, and <http://www.vqorthocare.com/Products/Electrotherapy/Orthostim4.php> which is not part of the MTUS

The Expert Reviewer his/her decision on the Chronic Pain Medical Treatment Guidelines, OrthoStim, Interferential Current Stimulation, page 118-120, which is part of the MTUS.

Rationale for the Decision:

The medical records provided were reviewed alongside the appropriate guidelines. According to the MTUS Chronic Pain Guidelines, OrthoStim combines four different types of stimulation: Interferential, Neuromuscular, High-Volt Pulsed Current and Pulsed Direct Current. Regarding Interferential Current Stimulation (ICS), the Chronic Pain Medical Treatment Guidelines states that this device is not recommended as an isolated intervention, as 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. Regarding Neuromuscular electrical stimulation (NMES devices),), the Chronic Pain

Medical Treatment Guidelines states that this device is also not recommended, as NMES are used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Based on the guidelines cited above, OrthoStim is not recommended for this employee due to limited evidence of effectiveness for the employee's signs and symptoms.

Therefore, the request for OrthoStim, EOC1, EOC2; purchase and supplies is not medically necessary or 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

/dat

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.