MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/5/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/12/2013
Date of Injury:	5/21/2007
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017586

1) MAXIMUS Federal Services, Inc. has determined the request for **electrical stimulator supplies is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **adhesive remover wipe is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 10/11/2013 disputing the Utilization Review Denial dated 8/12/2013. 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 **electrical stimulator supplies is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **adhesive remover wipe 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 PM & R, 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 patient is a 55 year old male air conditioning mechanic who was injured on March 14, 2005, when he noticed left knee pain after climbing a ladder. He states he routinely walks and climbs ladders repetitively for his job. He was placed on modified duty and given Naproxen. He then had physical therapy and was released to full duty. He was sent to an orthopedic surgeon who stated he had a left knee industrial strain/sprain, but there were no work restrictions. Then he gradually developed back pain radiating down the right leg. He was given Motrin and was told he had degenerative disc disease and right leg sciatica. Electromyography testing in 2007 on both legs was negative.

The application shows there is a dispute with the August 12, 2013 denial. The denial letter states they reviewed reports dated 7/15/13 from [redacted], but these reports were not available for this IMR. There is no exact description of the electrical stimulator supplies being requested.

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:

[redacted]

1) **Regarding the request for electrical stimulator supplies:**

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, TENS, pages 114-121, which are a part of MTUS.

Rationale for the Decision:
The requested electrical stimulator supplies are not fully described in the application request, nor in the medical records provided for review. It is noted that on March 11, 2013, the physician recommended a replacement ComboCare 4 unit. This is a combination unit that does TENS, infrared and neuromuscular electrical stimulation (NMES). This unit would not be in accordance with MTUS, as MTUS specifically states NMES is not recommended. In absence of a more exact description of the requested item, the NMES supplies cannot be confirmed as in accordance with MTUS guidelines. **The request for electrical stimulator supplies is not medically necessary and appropriate.**

2) **Regarding the request for adhesive remover wipe:**

Since the primary item is not medically necessary, none of the associated items 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
[redacted]

/dso

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.