

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 10/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	3/22/2012
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003340

- 1) MAXIMUS Federal Services, Inc. has determined the request for electrical muscle stimulation three times per week **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for continuance of psych treatment **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 muscle stimulation three times per week **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for continuance of psych treatment **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 Rehabilitation, 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 July 16, 2013:

“The employee was born [REDACTED]. Her underlying date of injury is 03/22/12. The referenced diagnoses include left ankle strain, ankle enthesopathy, lumbar strain, cervical and trapezius strain, muscle contraction headaches, sleep difficulties from medication, and anxiety/depression.”

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 Determination from Claims Administrator
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for electrical muscle stimulation three times per week:

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2004, 2nd Edition, Low Back Chapter, page 303, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS Chronic Pain Medical Treatment Guidelines, page 121, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported a work-related injury on 3/22/2012. The employee subsequently was treated for the following diagnoses: left ankle strain; ankle enthesopathy; lumbar strain; cervical and trapezius strain; muscle contraction; headaches; sleep difficulties for medication; anxiety; and depression. Treatment has included a home exercise program, H-wave unit, medication regimen, chiropractic treatment, and physical therapy. The employee reports continued complaints of low back pain with associated numbness and tingling to the bilateral lower extremity. A request was submitted for electrical muscle stimulation three times per week.

The MTUS Chronic Pain guidelines indicate neuromuscular electrical stimulation (NMES) is not recommended. NMES is used primarily as a part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The clinical documentation submitted for review evidenced the employee reported positive efficacy with the previous H-wave utilized at home. The clinical notes lack documentation of quantifiable increase in objective functionality and decrease in the employee's rate of pain as well as documentation of titration of meds. The request for electrical muscle stimulation three times per week **is not medically necessary or appropriate.**

2) Regarding the request for continuance of psych therapy:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 23, which is part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported a work-related injury on 3/22/2012. The employee subsequently was treated for the following diagnoses: left ankle strain; ankle enthesopathy; lumbar strain; cervical and trapezius strain; muscle contraction; headaches; sleep difficulties for medication; anxiety; and depression. Treatment has included a home exercise program, H-wave unit, medication regimen, chiropractic treatment, and physical therapy. The employee reports continued

complaints of low back pain with associated numbness and tingling to the bilateral lower extremity. A request was submitted for continuance of psych treatment.

The MTUS Chronic Pain guidelines indicate that with evidence of objective functional improvement, a total of up to 6 to 10 visits after 5 to 6 weeks is supported. The clinical notes continue to lack documentation of quantifiable objective functional improvements for this patient status post previous psychological interventions. In addition, the provider did not indicate a rationale for future treatment, duration or frequency for treatment, or goals of treatment. The request for continuance of psych therapy **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.