

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **11/25/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	12/22/1999
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0003911

- 1) MAXIMUS Federal Services, Inc. has determined the request for **replacement of Orthostim4 unit** is not **medically necessary and appropriate**.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 of Orthostim4 unit** 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 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:

The injured worker is 47 year old female with diagnoses of chronic low back pain, right wrist pain, right thumb ligament reconstruction, and lumbar spinal stenosis. PR-2 dated 03/12/13 indicates that the claimant complains of a flare up of pain in the low back due to sitting longer than 20 minutes. The claimant reports chiropractic treatment helped in the past to decrease pain and increase range of motion. The claimant is still interested in chiropractic treatment. Examination of the lower back shows tenderness over the paravertebral muscles, quadratus lumborum, sacroiliac joints, and gluteal muscles bilaterally. Straight leg raising is negative. Range of motion is still limited to 30 degrees of flexion, 8 degrees of extension, and 13 degrees of side bending. Neurologic function is intact. The provider recommends chiropractic treatment for the back pain flare up.

Primary treating physician's supplemental report dated 06/26/13 indicates that the claimant was diagnosed with status post right thumb ligament reconstruction performed on 12/07/04, lumbar spine sprain and strain, and fibromyalgia. During the course of the claimant's treatment, the claimant was initially treated with pain medications, physical therapy, acupuncture treatment, chiropractic treatment, OrthoStim4 unit, and home exercise program with temporary relief. The provider notes that in the most recent evaluation dated 05/31/13, the claimant noted improvement of pain in the low back. The claimant primarily complained of increased right thumb pain with inand- off flare ups. Examination of the lumbar spine showed tenderness over the lower lumbar and erector spinae muscles with restricted range of motion on flexion, right side bending, and left side bending. Straight leg raising test elicited pain in the lower back. Authorization for a dermatologist consultation was requested due to skin discoloration and authorization for replacement of OrthoStim4 unit was also requested. The provider currently notes that the claimant was diagnosed with systemic lupus erythematosus, which is a chronic autoimmune disease that causes inflammation and damage to the skin, joints, kidneys, heart, lungs, brain, nervous system, and mucous membranes, and various associated

symptoms. The claimant has been recently treated with Plaquenil, an antimalarial drug that is known to reduce skin problems in lupus and prevent pain and swelling in arthritis. Basing in the claimant's most recent evaluation, the claimant's current medication has failed to provide the claimant substantial benefit. As such, the provider recommends a referral to an appropriate medical specialist that can better address the claimant's skin discoloration primarily in the arms, face, and chest. The provider notes that the claimant was also being seen by a rheumatologist for the claimant's fibromyalgia. Based from the 05/31/13 report, the claimant was previously referred to a dermatologist who prescribed the claimant with Plaquenil. The provider noted that although the rheumatologist consult may be helpful, the dermatologist consult that have been treating the claimant's skin issue for a period of time would be more appropriate since the dermatologist is more familiar with the claimant's history and disease course. Pertaining to the replacement of OrthoStim4 unit, the provider notes that the claimant has been extensively afforded with all forms of conservative treatments including but not limited to pain medication and physical therapy methods with notable improvement of the claimant's symptoms. The provider is requesting a replacement unit since the claimant's previous use of the modality has been worn out that might hinder effectiveness of the device. Therefore, the provider recommends the reconsideration for dermatologist consultation and replacement of Orthostim4 unit.

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 replacement of Orthostim4 unit:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Neuromuscular Electrical Stimulation, pg. 117, and Interferential Current Stimulation (ICS) Guidelines, pgs. 115-116, which are part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate "Neuromuscular electrical stimulation (NMES devices) are Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to

rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. Functional neuromuscular stimulation (also called electrical neuromuscular stimulation and EMG-triggered neuromuscular stimulation) attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles to enable spinal-cord-injured or stroke patients to function independently, or at least maintain healthy muscle tone and strength. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation”

In the case of this request, the medical necessity of a multimodal device requires that all modalities are in accordance with the California MTUS. For neuromuscular stimulation, the MTUS specifies that this modality is used in cases of post-stroke rehabilitation, which does not apply to this employee. Furthermore, the interferential stimulation modality is generally not recommended by the MTUS, although a list of exceptions is suggested in the MTUS. **The request for replacement of Orthostim4 unit 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

/ldh

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.