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

Notice of Independent Medical Review Determination

Dated: 11/22/2013

[redacted]

[redacted]

Employee:	[redacted]
Claim Number:	
Date of UR Decision:	7/1/2013
Date of Injury:	8/1/2011
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004126

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

2) MAXIMUS Federal Services, Inc. has determined the request for CMF spinalogic bone growth stimulator **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for hot/cold contrast therapy 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 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 a muscle stimulator **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for CMF spinalogic bone growth stimulator **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for hot/cold contrast therapy 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 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.

Expert Reviewer Case Summary:
The patient is a 47-year-old male who reported an injury on 08/01/2011. MRI of the cervical spine dated 05/14/2013 revealed findings of a disc osteophyte complex at the C5-6 and C6-7 levels with no foraminal narrowing. AME completed on 05/28/2013 reported treatment recommendation regarding the cervical spine was deferred. The patient did have complaints of neck pain with numbness and tingling in the right hand. Clinical note dated 06/19/2013 reported the patient was recommended for a CDF at C5-6 and C6-7. The patient was recommended for associated hot/cold therapy, muscle stimulation, assistant surgeon, and medical clearance. Utilization Review dated 07/01/2013 reported the request for surgery was authorized, but bone growth stimulator, hot/cold therapy unit, and muscle stimulator were non-certified. Rationale included that Dr. [redacted] withdrew the request for hot/cold unit. Rationale also included no medical necessity for a muscle stimulator or bone growth stimulator. Clinical note dated 07/22/2013 reported the patient was pending surgery. Utilization Review dated 07/26/2013 reported the patient was authorized for right shoulder surgery.

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 a muscle stimulator:**

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 Chronic Pain Medical Treatment Guidelines, TENS, pg. 116, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Neuromuscular electrical stimulation (NMES devices), pg. 121, which is part of the MTUS.

Rationale for the Decision:
The employee received concurrent authorization for ACDF. Chronic Pain Medical Treatment Guidelines state there is no evidence to support NMES use in chronic pain. In addition, the current request does not include duration for proposed use. Furthermore, there is no indication why the employee would require this device in the postoperative phase. **The request for a muscle stimulator is not medically necessary and appropriate.**

2) **Regarding the request for CMF spinalogic bone growth stimulator:**

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 Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Bone-growth stimulators (BGS), which is not part of the MTUS.

Rationale for the Decision:
Official Disability Guidelines (ODG) state that bone growth stimulators in the cervical spine are currently under study. There is a lack of documentation to support the employee will have delayed healing necessitating the need for a bone growth stimulator. There are no serial postoperative radiographs

demonstrating nonunion of fusion sites. **The request for CMF spinalogic bone growth stimulator is not medically necessary and appropriate.**

3) **Regarding the request for hot/cold contrast therapy unit:**

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 Official Disability Guidelines (ODG).

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Cryotherapy, which is not part of the MTUS.

Rationale for the Decision:
The request was previously non-certified, as a treating provider withdrew the request. There is no subsequent documentation supporting why the treating provider now feels the employee should require a hot/cold contrast therapy unit. Furthermore, there is no duration for the proposed therapy unit. It is also unclear why the employee could not use cold/hot packs versus the need for a continuous cryotherapy unit. **The request for hot/cold contrast therapy 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.