

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 12/2/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	8/3/2011
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009772

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

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. 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 **interferential 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 Anesthesiology, and Pain Management and is licensed to practice in Georgia. 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 claimant is a 33-year-old male presenting with neck, back, knee, and ankle pain following a work-related injury. The claimant reports constant low back pain with radiation to the trapezius area. The pain is exacerbated by increased activity and decreased with rest. The physical exam was significant for restricted cervical range of motion, tenderness at the lumbosacral junction, back pain with recumbent straight leg raising on the right to 70° and left is 75°. X-rays of the spine were normal. The claimant was diagnosed with cervical spine herniated nucleus pulposus with tear, thoracic spine musculature ligamentous injury, lumbar spine and herniated nucleus pulposus, and history of gastritis. The claimant is requesting coverage for an interferential 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 interferential 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), Pain Chapter, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS), pg. 118-119, which is a part of the MTUS.

Rationale for the Decision:

Per MTUS, Interferential Current is “not recommended as an isolated intervention. 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain....The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues.” A review of the records indicates that interferential current was recommended as solo therapy for pain associated with cervical spine herniated nucleus pulposus, thoracic spine musculature ligamentous injury, and lumbar spine herniated nucleus pulposus. Per MTUS interferential current is not medically necessary as solo therapy with the employee’s current diagnoses. **The request for interferential 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

/pr

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.