

**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**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested 1-month home-based trial of neurostimulator transcutaneous electrical nerve stimulation – electrical muscle stimulator unit **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/6/2013 disputing the Utilization Review Denial dated 5/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/7/2013. 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 requested 1-month home-based trial of neurostimulator transcutaneous electrical nerve stimulation – electrical muscle stimulator 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, 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 24, 2013.

The patient is a 46 year old female who reportedly was injured on 3/28/13 when the door shut on her hand while pulling the cart injuring her knuckles and back. As per progress report dated 04/29/13, the patient complains of constant pain in her head. She rates her pain as 9. The patient notes of moderate to severe headaches present mostly at the forehead. She states that the pain occasionally involves the back of the head and sinus regions. She notes associated complaints of breathing difficulty, blurred vision, nausea, and dizziness. She also states that as a result of constant exposure to cleaning fumes and chemicals at work, she gradually developed headaches as well as breathing difficulty and eye irritation. Upon examination of the cervical spine, there is minimal paraspinal tenderness at levels C1-2, C2-3, C3-4, C4-5, C5-6, C6 7 and C7 and T1. Distraction test, Spurling test, Foraminal compression and Shoulder depressor test are negative on both sides. Based on the clinical information provided, the request for 1 Month Home Based Trial of Neurostimulator Transcutaneous Electrical Nerve Stimulation - Electrical Muscle Stimulator Unit is not recommended as medically necessary. Per evidence-based guidelines, there should be documentation of pain of at least 3 months duration, with evidence that other appropriate pain modalities have been tried and failed. This is an injury that occurred less than 2 months ago; therefore, there cannot be documentation of at least 3 months' pain duration. Also, there is no documentation that the patient has tried and failed other appropriate pain modalities. As such, medical necessity has not been established. Spoke to Dr. [REDACTED]. Currently this patient is attending acupuncture, and has only received 1-2 treatments. There is no indication of any formal active therapy participation or instruction to go along with home use of this modality. Additionally, guidelines recommend this unit after 3 months of persistent pain/symptoms. Therefore, the request is not medically warranted.

**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 by [REDACTED] (dated 5/24/13)
- Chronic Pain Medical Treatment Guidelines (2009) (pages 114-117)
- Medical Records from 3/29/2013 through 5/24/2013

**1) Regarding the request for 1-month home-based trial of neurostimulator transcutaneous electrical nerve stimulation – electrical muscle stimulator unit:****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 (2009) (pages 114-117), which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

**Rationale for the Decision:**

The employee was injured on 3/28/2013 and experienced constant pain in her head. The employee also experienced occasional pain in the back of the head and sinus regions. A request was submitted for a transcutaneous electrical nerve stimulation (TENS) unit.

The medical records support that multiple body parts are affected including the low back with a date of injury of 3/28/13. Per the Chronic Pain Medical Treatment Guidelines (pages 114-117), criteria for use of a TENS unit for intractable pain includes duration of pain for at least three months. The requests for the use of the TENS unit were all within the first three months from the date of injury. The requested neurostimulator transcutaneous electrical nerve stimulation – electrical muscle stimulator 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> 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.