
Notice of Independent Medical Review Determination

Dated: 8/29/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/15/2013
Date of Injury: 6/2/2012
IMR Application Received: 7/17/2013
MAXIMUS Case Number: CM13-0001884

- 1) MAXIMUS Federal Services, Inc. has determined the request for a pro-stim 5.0 purchase **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for supplies for 3 months (including electrodes, lead wires, and replacement batteries) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 pro-stim 5.0 purchase **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for supplies for 3 months (including electrodes, lead wires, and replacement batteries) **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 15, 2013.

“CLINICAL SUMMARY:

██████████ is a 49 year old (DOB: 08/05/63) male Youth Correctional Counselor, with a date of injury on 06/02/12 when he was assaulted by an inmate. The carrier has accepted: Facial Bones, Wrist (Left), Soft Tissue-Neck, Elbow (Left) and Lower Back Area. The carrier has Denied acceptance of the claim for shoulder (left). The current work status is: Modified duty. Does not appear modified duties available at his work place.”

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 by ██████████ (dated 7/15/13)
- Employee’s Medical Records by ██████████ (dated 6/3/12 thru 6/15/12)
- Employee’s Medical Records by ██████████ (dated 8/20/12)
- Employee’s Medical Records by ██████████ (dated 7/5/12)

- Employee's Medical Records by [REDACTED], MD (dated 7/5/12 thru 7/3/13)
- Request for Retro-Authorization by [REDACTED] (dated 1/30/13)
- Employee's Medical Records by [REDACTED] (dated 4/9/13 thru 5/7/13)
- Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, pgs. 114-117

1) Regarding the request for a pro-stim 5.0 purchase:

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), Transcutaneous electrotherapy, pgs. 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 6/2/12. The employee sustained injuries to the facial bones, left wrist, soft tissue of the neck, left elbow, and lower back. Treatment has included shoulder surgery, a cervical collar, a transcutaneous electrical nerve stimulation (TENS) unit, and medication. The request is for a pro-stim 5.0 purchase.

Per medical records submitted and reviewed, documentation shows that the pro-stim 5.0 unit contains neuromuscular electrical stimulation (NMES). This is specifically not recommended under Chronic Pain Medical Treatment Guidelines. TENS and interferential (IF) are not recommended as an isolated modality, and there are no records to suggest the employee is in an evidence-based program of functional restoration. The Pro-Stim 5.0 unit does not meet the Chronic Pain Medical Treatment Guidelines criteria. The request for a pro-stim 5.0 purchase is not medically necessary and appropriate.

2) Regarding the request for supplies for 3 months (including electrodes, lead wires, and replacement batteries):

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), Transcutaneous electrotherapy, pgs. 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 6/2/12. The employee sustained injuries to the facial bones, left wrist, soft tissue of the neck, left elbow, and lower back. Treatment has included shoulder surgery, a cervical collar, a TENS unit, and medication. The request is for supplies for 3 months (including electrodes, lead wires, and replacement batteries).

The Pro-Stim 5.0 unit does not meet the Chronic Pain Medical Treatment Guidelines criteria. The supplies by themselves (without the Pro-Stim 5.0 unit) are not functional and have no purpose in treating the employee's injuries. The 3-months supplies are listed as a part of the Pro-Stim 5.0 purchase. The request for supplies for 3 months (including electrodes, lead wires, and replacement batteries) 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

/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.