

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	9/10/2008
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005587

- 1) MAXIMUS Federal Services, Inc. has determined the request for Transcutaneous Electrical Nerve Stimulation (**TENS**) Unit with supplies purchase is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/16/2013. 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 **TENS) Unit with supplies purchase** 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 PM&R, has a subspecialty in Interventional Spine 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:

This patient had an initial date of injury of 09/10/2008. When the patient was seen by Dr. [REDACTED] on 6/24/2013 there was continued neck and back pain. She was attending physical therapy for her left shoulder and it was noted to be helpful. Exam showed focal tenderness in the lumbar spine. Strength was intact. The range of motion (ROM) was limited. The diagnoses included: cervical foraminal stenosis and anterolisthesis, lumbar spondylosis, facet arthrosis, bilateral shoulder impingement, bilateral knee tricompartmental arthritis, sleep disturbance, acute aggravation of her lumbar spine and GI complaints. The treatment plan was to follow-up with Dr. [REDACTED] physical therapy, and TENS 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:

[REDACTED]

1) Regarding the request for TENS) Unit with supplies purchase:

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 regarding TENS, pps 114-117, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS, page 116, which is part of MTUS.

Rationale for the Decision:

The utilization review letter dated 7/22/2013 modified the requested TENS unit with supplies purchase to a 30 day rental for a home trial. The progress reports dated 3/25/2013, 5/10/2013, 6/24/2013, 7/11/2013 By Dr. [REDACTED] did not indicate that the employee had received a 30 day trial of TENS unit therapy as an adjunct to the physical therapy. MTUS page 116 states that a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. It appears that the modification made by utilization review was reasonable and appropriate according to MTUS. **The request for TENS) Unit with supplies purchase 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

/cmol

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.