

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	7/19/1999
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006466

- 1) MAXIMUS Federal Services, Inc. has determined the request for **interferential unit supplies for 6 months is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/30/2013. 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 supplies for 6 months** 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 52-year-old female who sustained an occupational injury on 07/19/1999. Subsequently, the patient suffered a lumbar spine sprain. Imaging indicated L5-S1 is dark with broad herniated nucleus pulposus with right foraminal narrowing and moderate facets. L4-5 moderate facets and broad disc protrusions with mild bilateral foraminal narrowing, per MRI of 06/02/2009. Documentation submitted for review from 03/07/2012 indicates that the patient is performing a home exercise program, and that the patient presents with mechanical low back pain with no radicular symptoms. The patient has also undergone epidural steroid injection at L5-S1 in 06/2011. In addition to interferential home unit therapy, the patient is also taking Motrin 800 mg and Flexeril 7.5 mg.

### **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 supplies for 6 months:**

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 American College of Occupational and Environmental Medicine (ACOEM) Guidelines, which is part of the MTUS, and Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS chronic pain (transcutaneous electrical nerve stimulation), pages 114-115, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines indicate that use of transcutaneous electrical nerve stimulation by use of an interferential home unit for pain management is recommended for neuropathic pain, phantom limb pain, CRPS II, spasticity and multiple sclerosis. It further indicates that, although electrotherapeutic modalities are frequently used in the management of chronic low back pain, few studies were found to support their use. Furthermore, the ACOEM guidelines indicate that interferential therapy for subacute or chronic low back pain and other back disorders is not recommended. The records submitted for review lacks documentation of exceptional factors for the employee to continue with this treatment outside of the guidelines and is not recommended. **The request for interferential unit supplies for 6 months 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  
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Oakland, CA 94612  
/bh

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.