

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/7/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/20/2013 |
| Date of Injury: | 4/18/2012 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0007377 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for 2 month rental of OrthoStim4 unit with supplies between 7/19/2013 to 09/17/2013 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/20/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. 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 2 month rental of OrthoStim4 unit with supplies between 7/19/2013 to 09/17/2013 **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 44 year old male with a date of injury of 4/18/12. The patient's diagnoses include: chronic low back pain, lumbar radiculopathy, and lumbar facet syndrome. The 6/25/13 report by Dr. [REDACTED], M.D. noted that the patient was refractory to conservative treatment with anti-inflammatories, physical therapy, and epidural steroid injection. A 7/12/12 lumbar MRI report showed multilevel degenerative acquired moderate stenosis of the spinal canal and bilateral subarticular recesses at L3-4 and L4-5 levels due to diffuse dorsal low signal intensity disc protrusions with moderate facet hypertrophy; L5-S1 moderate to severe degenerative facet arthrosis.

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 and Provider)
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 2 month rental of OrthoStim4 unit with supplies between 7/19/2013 to 09/17/2013 :

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 (2009), which is part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines MTUS pg. 120.

Rationale for the Decision:

The medical records provided for review indicate that the employee has chronic low back pain and radicular symptoms that have not responded to conservative treatment. The medical record dated 7/15/13 noted a request for a 2 month rental of an OrthoStim 4 unit with supplies. No discussion was provided in regards to rational for the 2 month rental. MTUS does not support a 2 month trial of electrical stimulation with a combination unit. **The request for 2 month rental of OrthoStim unit with supplies between 7/19/2013 to 9/17/2013 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

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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.