
Notice of Independent Medical Review Determination

Dated: 10/8/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

4/22/2013

3/16/2013

5/9/2013

CM13-0000333

- 1) MAXIMUS Federal Services, Inc. has determined the request for a computerized range of motion test **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a functional capacity evaluation **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 12 chiropractic sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for an interferential unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Medrox **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/9/2013 disputing the Utilization Review Denial dated 4/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 computerized range of motion test **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a functional capacity evaluation **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 12 chiropractic sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for an interferential unit **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for Medrox **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 & 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 April 22, 2013:

“Occupation: [REDACTED]. MOI: Injury sustained when she and 3 partners carried a deceased victim weighing some 300 pounds down steps. Continued performing duties and about 2 hours later felt sharp pain in lower back but continued working the double shift. The following day had a lot of pain, took ibuprofen.
Subjective: Low back pain radiating down to (R) leg to toes with numbness, tingling.”

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 from [REDACTED]

- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for a computerized range of motion test:

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), Tables 8-8 and 12-8, 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 relied on the ACOEM Guidelines, Chapter 12, pages 292-295, which are part of the MTUS. The Expert Reviewer also cited the Official Disability Guidelines (ODG), Lumbar chapter, Flexibility section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury to the lower back and has experienced pain radiating to the right thigh, leg and toes. Treatment has included chiropractic manipulation and medication management. The request is for computerized range of motion test.

The ACOEM guidelines state that lumbar range of motion (ROM) is a part of a normal evaluation. In general standards of practice a dual inclinometer method is used, and computerized ROM is not necessary. The medical records do not indicate whether the computerized ROM testing is/was done as a separate procedure. The request for a computerized range of motion test **is not medically necessary and appropriate.**

2) Regarding the request for a functional capacity evaluation:

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), which is part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific page. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on ACOEM, Chapter 7, pages 137-138, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury to the lower back and has experienced pain radiating to the right thigh, leg and toes. Treatment has included chiropractic manipulation and medication management. The request is for a functional capacity evaluation.

The ACOEM guidelines state that to rely solely upon functional capacity evaluation (FCE) results for determination of current work restrictions and capabilities can be problematic. The ACOEM guidelines also indicate that there

is little evidence to confirm that a FCE predicts an individual's actual capacity to perform in the workplace. The medical records provided for review do not indicate that a FCE was requested or performed. The request for a functional capacity evaluation **is not medically necessary and appropriate.**

3) Regarding the request for 12 chiropractic sessions:

Medical Treatment Guideline(s) 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), 2nd Edition, (2007 Revision), pages 150-159, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pages 30 and 58, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury to the lower back, and has pain radiating to the right thigh, leg and small toe. Treatments have included chiropractic manipulation, and medication management. The request is for 12 chiropractic sessions.

The MTUS Chronic Pain Medical Treatment guidelines indicate that chiropractic sessions are widely used in the treatment of musculoskeletal pain. The MTUS Chronic Pain Guideline recommends a trial of 6 sessions, and with functional improvement, may be extended to 18 sessions. The current request for 12 chiropractic sessions is not in accordance with MTUS chiropractic recommendations. The request for 12 chiropractic sessions **is not medically necessary and appropriate.**

4) Regarding the request for an interferential unit (IF):

Medical Treatment Guideline(s) 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), 2nd Edition, (2004), but did not cite a specific page. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, page 120, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury to the lower back, and has pain radiating to the right thigh, leg and small toe. Treatments have included chiropractic manipulation, and medication management. The request is for an interferential unit (IF).

The MTUS Chronic Pain Medical Treatment guidelines indicate that an IF is used where pain is ineffectively controlled due to diminished effectiveness of medications or individual is unresponsive to conservative measures. In this case, there is lack of documentation of employee being unresponsive to conservative measures or pain medication. The request for an interferential unit **is not medically necessary and appropriate.**

5) Regarding the request for Medrox:

Medical Treatment Guideline(s) 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, 2nd Edition, (2004), Chapter 12, Tables 12-5 and 12-8, 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 relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 111-113, which is part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury to the lower back, and has pain radiating to the right thigh, leg and small toe. Treatments have included chiropractic manipulation, and medication management. The request is for Medrox.

The MTUS Chronic Pain Medical Treatment Guidelines indicate Medrox has capsaicin and is only an option in an individual who has not responded to other treatments. The MTUS Chronic Pain Guidelines indicate topical analgesics are recommended when trials of antidepressants and anticonvulsants have failed. In this case, the clinical notes do not indicate the failure of the first line of therapy. The request for Medrox **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

/hs

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.