

April 26, 2013

**Notice of Independent Medical Review Determination  
MAXIMUS Case No. CM13-000030**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

**Determination:** MAXIMUS Federal Services, Inc. has determined the 1 Back Hugger Elastic strap, 1 lumbar pillow Back Hugger, 1 Moist heating pad, and 1 back Theracane Massager requested are **not medically necessary**.

A request for a(n) Standard Independent Medical Review was filed with the Administrative Director, Division of Workers' Compensation. The case was assigned to MAXIMUS Federal Services as the designated Independent Medical Review Organization.

**Medical Qualifications of the Professional 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, has a subspecialty in Pain Medicine 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 professional 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.

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated February 14, 2013

According to the available medical records, the employee is a 55 year old female who sustained an industrial injury on January 14, 2013.

According to the documentation submitted by [REDACTED] the patient bent down to pick up a key and felt sharp, paralyzing lower back pain. Radiographs taken at ER were negative for fracture, but there was evidence of degenerative disc disease. She had a prior back surgery about 8 years ago. The patient took a Valium prior to her office visit. She describes the Pain as moderately severe to extremely severe. The pain is sharp and exacerbated by movement. She rates the pain 6/10. The symptoms are relieved by rest. She denies any radiation of pain or numbness. She reports weakness due to pain. On examination it is reported that the patient has abnormal gait, limited range of motion, Extension 0/30, left lateral flexion 0/45, right lateral flexion 0/45, lateral rotation left 20/30, right 20/30 deg. The patient is unable to sit because the pain intensifies. Unable to perform SLR or reflexes.

The treatment plan includes: etoladoc, tramadol, polar frost for pain, orphenidine, back brace, Theracane massager, back hugger and pillow strap, alternating hot/cold packs, and chiropractic care to expedite recovery, reduce pain, and increase function 3x2.”

### Documents Reviewed for Determination:

The interested parties were notified that the review was assigned on a standard basis. The relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for IMR
- Utilization Review (completed by [REDACTED])
- Employee's Medical Records from [REDACTED] (dated 1/17/13 through 04/05/13)

### Professional Reviewer's Rationale Regarding the Following Treatment Requests:

1. Back Hugger Pillows and straps
2. Heat Therapy/Moist heating pads
3. Theracane Massager

#### 1. Back Hugger Pillows and straps:

Medical Treatment Guideline(s) Relied Upon by the Maximus Professional Reviewer:

The Claims Administrator based its decision on Official Disability Guidelines (ODG) (2009) Low Back Section. The provider did not dispute the guidelines used by the

Claims Administrator. The Medical Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance. Maximus Professional Reviewer's Rationale:

With regard to the request for the low back hugger elastic strap and lumbar back hugger pillow, the California M.T U.S. do not have specific provisions for these two devices. According to the CA-MTUS, if there are no specific recommendations in a guideline, then national evidence-based community standards of care are applied instead. There are no peer reviewed, evidence based clinical trials in regard to these two ergonomic products. The Official Disability Guidelines also do not have provisions for these products." Given these guidelines, the request for the elastic strap and hugger pillow is recommended for non-certification.

## **2. Heat Therapy/Moist heating pad:**

Medical Treatment Guideline(s) Relied Upon by the Maximus Professional Reviewer:

The Claims Administrator based its decision on Official Disability Guidelines (ODG) (2009) Low Back Section. The provider did not dispute the guidelines used by the Claims Administrator. The Medical Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

Maximus Professional Reviewer's Rationale:

With regard to the request for a moist heating pad, the ODG and California MTUS both recommend heat therapy as a conservative option in lumbar strain. However, as previously noted by the previous utilization review determination, there has already been certification for heat therapy in the form of a hot therapy pack that has been authorized. The moist heating pad is a duplicate request and is recommended for non certification.

## **3. Theracane Massager:**

Medical Treatment Guideline(s) Relied Upon by the Maximus Professional Reviewer:

The Claims Administrator based its decision on Official Disability Guidelines (ODG) (2009) Low Back Section. The provider did not dispute the guidelines used by the Claims Administrator. The Medical Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

Maximus Professional Reviewer's Rationale:

With regard to the request for the Theracane massager, this is a tool which allows a patient to perform self-massage to the spine and paraspinal muscles. There are no specific provisions for this device as durable medical equipment in the California MTUS or Official Disability Guidelines. Furthermore, there are no peer-reviewed evidence

based trials of this device. Given the guidelines, this request is recommended for non certification.

**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 Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Division of Workers Compensation  
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