MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/24/2013

Employee:	[redacted]
Claim Number:	[redacted]
Date of UR Decision:	7/17/2013
Date of Injury:	10/12/2005
IMR Application Received:	8/13/2013
MAXIMUS Case Number:	CM13-0010426

DEAR Law Offices Of [redacted],

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

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)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented [redacted] employee who has filed a claim for chronic knee pain, chronic pain syndrome, osteoarthrosis of the knees, myalgias, myositis, chronic mid back pain, and chronic low back pain reportedly associated with an industrial injury of October 12, 2005.

Thus far, the applicant has been treated with the following: Analgesic medications; adjuvant medications; psychotropic medications; topical compounds; and extensive periods of time off of work, on total temporary disability.

In a utilization review report of July 17, 2013, the claims administrator partially certified a 10-panel urine drug screen, denied home health services, denied stay in a short-term rehab facility, and certified prescriptions were BuTrans, Norco, and Motrin. Colace is also certified while Ativan was non-certified.

The applicant's attorney later appealed on August 9, 2013.

In a progress note of September 17, 2013, it is noted that the applicant remains off of work, on total temporary disability. She is pending surgery. Her pain ranges from 7-9/10. It is stated that the medications reduced her pain score by 1 to 2 points. She is somewhat overweight with a BMI of 32. She is status both knee and spine surgery. She is asked to continue BuTrans, Norco, Motrin, Ativan, and Colace. Other topical compounds are endorsed.

An earlier note of July 3, 2013 suggested that the applicant is contemplating a total knee arthroplasty.

Finally, in a note of July 15, 2013, the attending provider refilled numerous medications, noted that the applicant wants to pursue knee surgery, states that her knee is giving out, and refilled several of the applicant's medications.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Urine drug screen is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS and the Official Disability Guidelines, Urine Drug Testing, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Drug Testing, page 43, which is part of the MTUS and the Official Disability Guidelines, Criteria for Urine Drug Testing, which is not part of the MTUS.

The Physician Reviewer's decision rationale:
The claims administrator previously partially certified the request as a conventional 10-drug urine drug panel. The results of the same have not been provided for review. While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does endorse intermittent urine drug testing in the chronic pain population, the MTUS does not specifically state parameters for or frequency with which to perform urine drug testing. The ODG urine drug testing topic does note that the Department of Transportation guidelines represent the most legally defensible framework of testing and further suggest that treating providers furnish a precise list of which drugs they intend to test for and also furnish the applicant's medication list prior to performing testing. In this case, the attending did not furnish a list of tests on the drug test panel that he wished to perform. Therefore, the original utilization review decision is upheld.

2. Home health care seven days a week for two weeks is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Home Health Services, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home Health Services, page 51, which is part of the MTUS.

The Physician Reviewer's decision rationale:
The attending provider has not clearly stated why these home health services are being sought. Based on the limited information on file, this appears to represent assistance for performance of activities of daily living following planned knee surgery. Per page 51 of the MTUS Chronic Pain Medical Treatment Guidelines, provision of home health services for assistance with activities of daily living alone are not endorsed. It is further noted that the applicant has stated on June 3, 2013 strangers in her home are fearful. For all of these reasons, the original utilization review decision is upheld. The request remains non-certified.

3. Short-term rehabilitation facility for two weeks is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, which is part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Knee & Leg Chapter, Skilled nursing facility LOS (SNF).

The Physician Reviewer's decision rationale:
The MTUS does not specifically address the topic of postoperative rehab in a skilled nursing facility. The ODG knee and leg chapter skilled nursing facility topic does support postoperative rehabilitation in skilled nursing facilities (SNF), as earlier and more intense rehabilitation is associated with better outcomes following a total knee arthroplasty. In this case, the applicant appears to be an individual with multiple foci of pain, superimposed on psychiatric issues. She may, indeed, benefit from a two-week stay in a short-term rehab facility. Therefore, the original utilization review decision is overturned. The request is certified.

4. Ativan 1mg 1-2 po, qhs #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 24, which is part of the MTUS.

The Physician Reviewer's decision rationale:
As noted on page 24 of the MTUS Chronic Pain Medical Treatment Guidelines, long-term or chronic usage of Ativan or other benzodiazepines is not endorsed, for pain, anxiety, depression, or any other purpose as there are many other drugs that are considered more effective for each purpose. Therefore, the original utilization review decision is upheld. The request is non-certified, on independent medical review.

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.

[redacted]

CM13-0010426