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

Notice of Independent Medical Review Determination

Dated: 11/27/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/15/2013
Date of Injury:	1/15/2013
IMR Application Received:	8/26/2013
MAXIMUS Case Number:	CM13-0016123

1) **MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 inferential unit is not medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 electric heat pad is medically necessary and appropriate.**

3) **MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 lumbar sacral orthosis is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 retrospective request for 1 inferential unit** is not **medically necessary and appropriate.**

2) **MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 electric heat pad** is **medically necessary and appropriate.**

3) **MAXIMUS Federal Services, Inc. has determined the retrospective request for 1 lumbar sacral orthosis** 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 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 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 applicant is a represented [redacted] employee who has filed a claim for chronic mid back, chronic knee, and chronic low back pain reportedly associated with an industrial injury of January 15, 2013.

Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; unspecified amounts of physical therapy; transfer of care to and from various providers in various specialties; at least 12 sessions of chiropractic manipulative therapy to date; and extensive periods of time off of work, on total temporary disability.

In a Utilization Review Report of August 15, 2013, the claims administrator denied a request for an interferential unit, lumbosacral orthosis, and an electric heating pad. The applicant's attorney subsequently appealed, on August 22, 2013.

An earlier note of August 28, 2013 is notable for comments that the applicant is pending extracorporeal shockwave therapy, chiropractic treatment, and will remain off of work, on total temporary disability.

Earlier notes of May 29, 2013 and April 17, 2013, also notes that the applicant remains off of work, on total temporary disability.

Finally, a handwritten note which appeared to be dated July 17, 2013, employs preprinted checkboxes and failed to furnish any narrative history. It is notable for multifocal complaints of neck, mid back, low back, wrist, knee, and ankle pain. The applicant exhibits associated tenderness to touch, and is asked to pursuit additional chiropractic manipulative therapy, obtain extracorporeal shockwave therapy, obtain topical compounds, and obtain pain management consultation while remaining off of work, on total temporary disability.

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 retrospective request for 1 inferential unit :**

<u>Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision</u>
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 120, which is part of the MTUS.

<u>Rationale for the Decision:</u>
Chronic Pain Medical Treatment Guidelines, do tepidly endorse a trial of interferential stimulator in those applicant's in whom pain is ineffectively controlled secondary to diminished ineffectiveness of medications, history of substance abuse that will make provision of analgesic medications unwise, and/or unresponsive to other conservative measures. In this case, however, the documentation on file is sparse and fails to clearly detail or describe whether or not the employee has had a prior successful one-month trial of said interferential stimulator. It does not appear, based on the documentation on file, that the employee has completed a prior successful one-month trial of the interferential stimulator. Purchase of the same cannot be supported without evidence of a successful prior trial. Accordingly, the original utilization review decision is upheld. **The retrospective request for 1 inferential unit is not medically necessary and appropriate.**

2) **Regarding the retrospective request for 1 electric heat pad:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, Chapter 12, Physical methods, which is part of the MTUS.

Rationale for the Decision:
ACOEM Guidelines in chapter 12 indicate simple, at-home applications of heat and cold are recommended. In this case, the proposed electric heating pad does represent a simple, at-home local application of heat which is recommended by ACOEM. Accordingly, the original Utilization Review decision is overturned. **The retrospective request for 1 electric heat pad is medically necessary and appropriate.**

3) **Regarding the retrospective request for 1 lumbar sacral orthosis:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision
The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Low Back Complaints, Chapter 12, which is part of the MTUS.

Rationale for the Decision:
ACOEM Guidelines in chapter 12 indicate lumbar supports have not been showed to have any lasting benefits beyond the acute phase of symptom relief. In this case, the employee is little under 10 months removed from the date of injury. Providing a lumbar support in this context is not indicated. Accordingly, the original utilization review decision is upheld. **The retrospective request for 1 lumbar sacral orthosis 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

/ldh

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.