
Notice of Independent Medical Review Determination

Dated: 9/13/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/3/2013
Date of Injury:	4/11/2012
IMR Application Received:	7/16/2013
MAXIMUS Case Number:	CM13-0001633

- 1) MAXIMUS Federal Services, Inc. has determined the request for a Vacutherm cold therapy unit with a back wrap **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/18/2013. 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 Vacutherm cold therapy unit with a back wrap **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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013.

Clinical Documents - 06/27/2013 8:52:00 AM). The date of injury is 04/11/12 (1 year ago). [REDACTED] is a 59-year-old man with low back pain. The injury occurred secondary to lifting. The patient underwent lumbar fusion from L3 to L5 on 5/30/13. Requested was a cold/compression therapy unit for 30 days.

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 Determination by [REDACTED] (dated 7/3/13)
- Agreed Medical Evaluation by [REDACTED], M.D. (dated 2/5/13)
- Progress Reports by [REDACTED] (dated 1/8/13 to 4/23/13)
- Medical Records by [REDACTED], M.D. (dated 1/15/13 to 6/19/13)
- Medical Records by [REDACTED] (dated 6/11/13 to 6/13/13)
- Official Disability Guidelines (ODG) – Low Back Chapter, Cold/Heat Packs section; Knee/Leg Chapter, Continuous-Flow Cryotherapy section

1) Regarding the request for a Vacutherm cold therapy unit with a back wrap:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) – Low Back Chapter, Cold/Heat Packs section, and Knee/Leg Chapter, Continuous-Flow Cryotherapy section, which are medical treatment guidelines

that are 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 determined that the MTUS does not address the issue in dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 4/11/2012 and has experienced chronic low back pain. The employee was diagnosed with multilevel foraminal stenosis and lumbar radiculopathy. Treatment has included medications, hot/cold packs, lumbar support, physical therapy and an L3-5 lumbar fusion on 5/30/2013. A request was submitted for a Vacutherm cold therapy unit with a back wrap.

The ODG indicates that the use of constant controlled cold therapy units with pumps or portable refrigerators has not been shown to offer any clinically significant benefit over passive methods of delivering cold therapy. The request is not supported by the guideline. The request for a 30 day rental of a Vacutherm cold therapy unit with a back wrap 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

/sab

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.