
Notice of Independent Medical Review Determination

Dated: 8/27/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]
6/28/2013

3/29/2013

7/16/2013

CM13-0001673

- 1) MAXIMUS Federal Services, Inc. has determined the request for a qualified functional capacity evaluation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for electrical muscle stimulation for the lumbar spine and left ankle (3 times a week for 2 weeks) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for infrared therapy for the lumbar spine and left ankle (3 times a week for 2 weeks) **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 6/28/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/18/2013. 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 qualified functional capacity evaluation **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for electrical muscle stimulation for the lumbar spine and left ankle (3 times a week for 2 weeks) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for infrared therapy for the lumbar spine and left ankle (3 times a week for 2 weeks) **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 Orthopaedic Surgery 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 June 28, 2013.

Clinical summary: According to Progress Report dated 06/17/13 by Dr. [REDACTED] the patient complained of intermittent moderate pain that was described as burning. The pain was aggravated by prolonged sitting and standing. The patient also complained of constant severe pain that the patient described as muscle ache, burning, and occasional sharp. This pain was aggravated by bending the ankle, walking, standing, and climbing stairs. The patient also reported pins and needles sensation. On examination: There was +3 spasm and tenderness to the left piriformis muscle, bilateral lumbar paraspinal muscles from L1 to S1 and multifidus. Lumbar range of motion was captured digitally by Acumar. A report and graph are attached. Kemp's test was positive bilaterally. This straight leg raise test was positive on the left. Braggard's was positive on the left. Yeoman's was positive bilaterally. The left hamstrings reflex was decreased. The left Achilles reflex was decreased. On ankle examination: the patient was wearing an ankle support on left ankle; there was +3 spasm and tenderness to the left lateral malleolus, peroneus longus, extensor hallucis and achilles tendon; Valgus test was positive on the left; A-P Drawer test was positive on the left; I P-A Drawer test was positive on the left. Functional improvement since the last examination had been shown by an increase in range of motion for the lumbar spine flexion from 35 to 45, extension 15 to 20 and left bending from 12 to 22 as well as a decreased in the visual analog scale rating increased from 6.0 to 5.0. The left ankle range of motion had also improved in flexion from 10 to 15, extension 25 to 30 and inversion 10 to 15. The patient was diagnosed with lumbar Disc Displacement with Myelopathy; Lesion of Sciatic Nerve; tendinitis, Bursitis, Capsulitis of the Left Foot; and left Ankle Sprain / Strain. This is a request Electrical Muscle

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:

- Applications (3) for Independent Medical Review
- Utilization Review Determinations (3) by [REDACTED] (dated 6/28/13)
- Medical Records by [REDACTED] (dated 5/16/13 to 7/24/13)
- American College of Occupational and Environmental Medicine (ACOEM), (2011 version) – Chapter 6, Independent Medical Examinations and Consultations
- Official Disability Guidelines (ODG) – Low Back Chapter, Neuromuscular Electrical Stimulators section and Infrared Therapy section; Ankle and Foot Chapter, Functional Electrical Stimulation section

1) Regarding the request for a qualified 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) – Chapter 7, pages 132-139, 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 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 3/29/2013 and experienced pain and strains in the lumbar spine, left leg, and left ankle. Treatment to date has included ice packs, Biofreeze, bandage to the left ankle, x-rays of the left ankle, medication, a cane, a back brace, and 6 sessions of physical therapy. A request was submitted for a qualified functional capacity evaluation (FCE).

Chapter 7 of the ACOEM Guidelines indicates there is little scientific evidence confirming FCEs predict an individual's actual capacity to perform in the workplace. An FCE reflects what an individual can do on a single day, at a particular time, and under controlled circumstances, which provides an indication of that individual's abilities. The medical records submitted and reviewed indicate the employee has utilized a course of physical therapy, but no physical therapy progress notes were submitted for review. The documentation submitted does not support the request. The request for a qualified functional capacity evaluation is not medically necessary and appropriate.

2) Regarding the request for electrical muscle stimulation for the lumbar spine and left ankle (3 times a week for 2 weeks):

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, Neuromuscular Electrical Stimulators section; Ankle and Foot Chapter, Functional Electrical Stimulation section, 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 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 3/29/2013 and experienced pain and strains in the lumbar spine, left leg, and left ankle. Treatment to date has included ice packs, Biofreeze, bandage to the left ankle, x-rays of the left ankle, medication, a cane, a back brace, and 6 sessions of physical therapy. A request was submitted for electrical muscle stimulation for the lumbar spine and left ankle (3 times a week for 2 weeks).

The ODG indicates electrical stimulation is utilized for patients who are status post spinal cord injury and have completed a training program that includes physical therapy sessions with the device over a 3 month period. The guidelines also indicate this modality is primarily supported for patients with atrophy or spasticity secondary to central nerve system lesions. The medical records received and reviewed lack evidence of any atrophy or spasticity. The records document the employee previously utilized a course of physical therapy, but no physical therapy progress notes were submitted for review. The guideline criteria are not met. The request for electrical muscle stimulation for the lumbar spine and left ankle (3 times a week for 2 weeks)**Error! Reference source not found.** is not medically necessary and appropriate.

3) Regarding the request for infrared therapy for the lumbar spine and left ankle (3 times a week for 2 weeks):

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, Infrared Therapy section, 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 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 3/29/2013 and experienced pain and strains in the lumbar spine, left leg, and left ankle. Treatment to date has included ice packs, Biofreeze, bandage to the left ankle, x-rays of the left ankle, medication, a cane, a back brace, and 6 sessions of physical therapy. A request was submitted for infrared therapy for the lumbar spine and left ankle (3 times a week for 2 weeks).

The ODG indicates infrared therapy is not recommended over heat therapy. The ODG indicates a limited trial of infrared therapy for treatment of acute low back pain may be appropriate, but only if used as an adjunct to a program of evidence-based conservative care. The clinical notes document the patient previously utilized a course of physical therapy, but no physical therapy progress notes were submitted for review. The medical records submitted do not support the request. The request for infrared therapy for the lumbar spine and left ankle (3 times a week for 2 weeks) is not medically necessary or 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

/dj

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.