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**Notice of Independent Medical Review Determination**

Dated: 10/24/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/8/2013  
Date of Injury: 12/20/2007  
IMR Application Received: 7/19/2013  
MAXIMUS Case Number: CM13-0001874

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 urine specimen collection **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 sleep number bed **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 6 localized intense neurostimulation therapy sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 6 extracorporeal shock wave therapies sessions **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 1 urine specimen collection **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 sleep number bed **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 6 localized intense neurostimulation therapy sessions **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for 6 extracorporeal shock wave therapies sessions **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 & 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 8, 2013:

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The patient is a 68 year old male with a date of injury of 12/20/2007. Under consideration for authorization are prospective requests for 1 sleep number bed; 6 LINT therapy sessions; and 6 extracorporeal shock wave therapy sessions. The provider is also requesting retrospective certification for 1 urine specimen collection performed on 6/7/2013.

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Per the 6/11/13 report of Dr. [REDACTED] the patient presented on 6/7/13 with complaints of mild to moderate

low back pain with bilateral hip pain. He indicated his pain had been increased lately due to increased physical activity. Objective exam findings revealed tenderness to palpation over the paraspinal musculature and also over the spinous process as well as over the gluteal musculature. The provider diagnosed the patient with lumbar discopathy, L4-L5, and L5-S1; healed left foot fracture; and sleep disturbance. Dr. [REDACTED] indicated the patient has a 9 mm disc herniation in his low back. No medication was prescribed at the time of the office visit. A urine specimen was obtained to monitor medication use. The patient was instructed to return within six weeks, and the provider declared the patient to remain temporarily totally disabled. Prior care has also included physical therapy, acupuncture, epidural steroid injection, cortisone injection, back brace, and chiropractic treatment. Dr. [REDACTED] 9/9/11 report summarized the patient's lumbar MRI as follows: 9mm spine canal with severe spine stenosis at L3-4, disc protrusion, and degeneration with spine stenosis at L4-5 and L5-S1 along with retrolisthesis.

### **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 (dated 7/19/13)
- Utilization Review by [REDACTED] (7/8/13)
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records Submitted by Claims Administrator (6/29/12 to 6/11/13)

### **1) Regarding the request for 1 urine specimen collection:**

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

The Claims Administrator based its decision on the Chronic Pain Guidelines (2009), Opiates, steps to avoid misuse/addition, (no page cited), part of the Medical Treatment Utilization Schedule (MTUS) and the University of Michigan Health Systems Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing controlled Substances (May 2009), pg. 10, pg. 32 – 33, a medical treatment guideline, not part of the MTUS. The Expert Reviewer did not find the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance. The Expert Reviewer found the Chronic Pain Guidelines (2009), Drug Testing, pg. 43, and Steps to avoid opioid misuse, pg. 94-95, part of the MTUS, applicable and relevant to the issue at dispute.

#### Rationale for the Decision:

The employee sustained a work-related injury on 12/20/07. The medical records submitted and reviewed indicate diagnoses of lumbar discopathy, L4-L5, and L5-S1, healed left foot fracture and sleep disturbance. Treatments have included physical therapy, acupuncture, epidural steroid injection, cortisone injection, back brace, chiropractic treatment, and medication management. The request is for 1 urine specimen collection.

The MTUS Chronic Pain guidelines indicate urine toxicology screens as an option to assess for the presence of illegal drugs and to avoid opioid misuse/addition. The submitted and reviewed clinical notes indicate that the employee is prescribed opiate pain medications. The guidelines support a urine screen in this case. The request for 1 urine specimen collection **is medically necessary and appropriate.**

## 2) Regarding the request for 1 sleep number bed:

### 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) (2009), Low Back – Lumbar & Thoracic (Acute & Chronic), Mattress selection, a medical treatment guideline not part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer found no section of the MTUS was applicable and relevant to the issue at 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 sustained a work-related injury on 12/20/07. The medical records submitted and reviewed indicate diagnoses of lumbar discopathy, L4-L5, and L5-S1, healed left foot fracture and sleep disturbance. Treatments have included physical therapy, acupuncture, epidural steroid injection, cortisone injection, back brace, chiropractic treatment, and medication management. The request is for 1 sleep number bed.

The Official Disability guidelines do not recommend a specialized mattress for the treatment of low back pain stating there are no high quality studies to support purchase of any type of specialized mattress or bedding for the treatment of low back pain. Therefore, the request for 1 sleep number bed **is not medically necessary and appropriate.**

## 3) Regarding the request for 6 localized intense neurostimulation therapy sessions:

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

The Claims Administrator found the Medical Treatment Utilization Schedule (MTUS), the Official Disability Guidelines, a medical treatment guideline (MTG), and the National Guidelines Clearinghouse did not provide any evidence-based recommendations and no scientific literature addressed the issue at dispute. The Expert Reviewer found the Medical Treatment Utilization Schedule (MTUS), the Official Disability Guidelines, a medical treatment guideline (MTG), and the National Guidelines Clearinghouse did not provide any evidence-based recommendations and no scientific literature addressed the issue at dispute.

### Rationale for the Decision:

The employee sustained a work-related injury on 12/20/07. The medical records submitted and reviewed indicate diagnoses of lumbar discopathy, L4-L5, and L5-S1, healed left foot fracture and sleep disturbance. Treatments have included physical therapy, acupuncture, epidural steroid injection, cortisone injection, back brace, chiropractic treatment, and medication management. The request is for 6 localized intense neurostimulation therapy (LINT).

LINT is not discussed in MTUS, medical treatment guidelines or the National Clearinghouse. The utilization review denied this request stating LINT is experimental. There is no description of what the procedure is, or how it is intended to cure or relieve the employee's back pain or disc herniation. Therefore, the request for 6 localized intense neurostimulation therapy (LINT) is **not medically necessary and appropriate**.

**4) Regarding the request for 6 extracorporeal shock wave therapies (ECSWT) sessions:**

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

The Claims Administrator found the Medical Treatment Utilization Schedule (MTUS), the Official Disability Guidelines, a medical treatment guideline (MTG), and the National Guidelines Clearinghouse did not provide any evidence-based recommendations and no scientific literature addressed the issue at dispute. 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 (ODG), Ankle and Foot Chapter, Extracorporeal shockwave therapy (ESWT), Elbow Chapter, Extracorporeal shockwave therapy (ESWT), a MTG, and the Aetna Clinical Policy Bulletin #0649, "Extracorporeal Shock-wave therapy for musculoskeletal indications and soft tissue injuries", a nationally-recognized professional standard.

Rationale for the Decision:

The employee sustained a work-related injury on 12/20/07. The medical records submitted and reviewed indicate diagnoses of lumbar discopathy, L4-L5, and L5-S1, healed left foot fracture and sleep disturbance. Treatments have included physical therapy, acupuncture, epidural steroid injection, cortisone injection, back brace, chiropractic treatment, and medication management. The request is for 6 extracorporeal shock wave therapies (ECSWT).

The Official Disability Guidelines mention ECSWT for the elbow and foot, but do not recommend it due to a lack of convincing evidence. The Aetna Clinical Policy Bulletin #0649 does not support ECSWT for the low back as this procedure is considered experimental. The request for 6 extracorporeal shock wave therapies (ECSWT) 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.