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: 10/3/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/8/2013
Date of Injury:	7/24/2012
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0001932

1) MAXIMUS Federal Services, Inc. has determined the request for a 3 month rental of Solar Care Far-Infrared Heating System **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/22/2013. 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 3 month rental of Solar Care Far-Infrared Heating System **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 8, 2013:

"The reported injury date was nearly one year ago. The only clinical documentation submitted for review was the provider's 5/i 7/13 progress report. This states "The patient previously was provided with a Solar Care unit and experienced marked relief of symptomatology with this unit," The duration of prior use was not specified. The "symptomatology" relieved was not specified. Functional benefits were not specified. The extent of symptom relief beyond "marked" was not quantified or otherwise characterized. Prior applications of heat therapy with warm compresses or other simpler means were not mentioned. Patient participation in an independent exercise/active rehab regimen as an adjunct to this passive treatment device was not satisfactorily delineated. This unit was "recommended for continued treatment of the patient's lumbar spine, right hip, and inguinal area." It is unclear why this unit was not recommended to treat the patient's "frequent and moderately severe neck pain, which radiates to the bilateral upper extremities rated 7 8/10." The patient also complained of frequent and moderately severe mid back pain, rated 8/10." pain relief and gradations thereof associated with prior use of the requested device were not delineated. Although lumbar spine pain radiated "to the right groin region and right lower extremity" there was no mention of right hip pain per se. The provider stated the requested equipment is necessary "to help facilitate rapid recovery" but since the injury occurred nearly 10 months prior "rapid recovery" is precluded and it is unclear how this could be considered a treatment goal. The provider stated this device "is supported in ACOEM, ODG and MTUS guidelines" but citations from these guidelines substantiating this claim were not noted. Provider stated "the requested DME can cure and/or relieve the patient from symptoms associated with their condition" but it is unclear how this device can accomplish those goals since the patient continued to complain of 7 8/10 radiating neck

pain and 8/10 radiating low back pain despite prior the use of the device. Noother evidence was presented that prior use of this device resulted in substantial symptom relief and/or produced a curative effect. Records submitted lack documentation regarding treatment prior to the provider's evaluation nearly 10 months after the reported injury date. This request is not supported by documentation submitted or review criteria."

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 (received 7/18/13)
- Utilization Review Determination (dated 7/8/13)
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule

1) **Regarding the request for a 3 month rental of a Solar Care Far-Infrared Heating System:**

   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 8, Table 8-8, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG) – Low Back Chapter, Infrared Therapy (IR) section, which is a medical treatment guideline that is not part of the 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 relied on the ODG section used by the Claims Administrator.

   Rationale for the Decision:
   The employee sustained a work related injury on July 24, 2012 resulting in back and groin pain. The medical records provided for review indicate the employee was diagnosed with bilateral adductor tendinitis. Treatments have included imaging studies, home application of moist heat therapy, and non-steroidal anti-inflammatory drugs. The request is for a 3 month rental of Solar Care Far-Infrared Heating System.

   The ODG guideline states infrared heat is not recommended over other heat therapies. A medical report dated 11/26/2012 indicates the employee was recommended for home application of heat, but there is no documentation submitted to show whether the employee had benefit with the moist heat. The documentation submitted does not support the request. The request for a 3 month rental of Solar Care Far-Infrared Heating System 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

/slm

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.