

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/27/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/9/2013
Date of Injury: 12/22/2008
IMR Application Received: 7/22/2013
MAXIMUS Case Number: CM13-0002366

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 56-year-old female who reported an injury on 12/22/2008, when she is reported to have fallen. The patient is reported to continue to complain of pain of the cervical, thoracic, and lumbar spine, and to have findings of pain on palpation and a kyphosis of the thoracic spine, decreased range of motion of the cervical spine, with decreased sensory exam of the left side in the C4-5, C5-6, and C6-7 dermatomes. The patient is noted to have a surgical incision of the lumbar spine secondary to a lumbar fusion. The patient is noted to have undergone urine drug screens on 03/05/2013, 05/07/2013 and 06/04/2013, which were reported to be negative for any abnormal findings. On 03/21/2013, the patient underwent a CT of the cervical spine without contrast, which noted multilevel degenerative changes throughout the cervical spine with multilevel neural foraminal narrowing with no evidence of acute compression fractures noted. A CT of the thoracic spine performed on 03/21/2013 reported multilevel degenerative changes throughout the thoracic spine as detailed. An MRI of the lumbar spine with contrast performed on 03/29/2013 reported postsurgical changes of the lumbar spine from L3-4 through L4-5 and partially at L5-S1 with no central canal or neural foraminal narrowing identified, subtle anterolisthesis of L3-4 at the level of the laminectomy, and posterior interbody fusion, degenerative changes of the lumbar spine with no definite evidence of central canal or neural foraminal narrowing and a compression fracture at the T12 vertebral body, age undetermined, with no evidence of retropulsion of the fracture fragments. The patient is noted to be on prescribed Norco 10/325 mg 1 every 6 to 8 hours as needed for pain.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

- 1. One urine drug screen is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Drug Testing, page 43, Opioids – On-going Management, page 78 and Opioids – Steps to avoid misuse, page 94-95, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The patient is a 56-year-old female who reported an injury to her neck, thoracic, and lumbar spine in 2008. She is noted to have undergone a lumbar spinal fusion in 10/2011, which consisted of anterior and posterior lumbar fusion with transpedicular screws. She was reported to complain of ongoing back pain and is noted to have multilevel degenerative changes of the cervical spine, multilevel neural foraminal narrowing, and a compression fracture at T12 vertebral body without evidence of retropulsion of the fracture fragment and a previous lumbar fusion at L3-4 through L5-S1. The patient is noted to be prescribed Norco 10/325 mg 1 tablet every 6 to 8 hours as needed for pain. She is noted to have undergone three urine drug screens within a 6 month period, which were negative for any findings. The California MTUS Guidelines recommend the use of random drug screens for patients to avoid misuse or addiction. However, as there is no documentation of suspicion of a misuse of medication, nor is there documentation that the patient requests frequent drug refills, or has other signs of drug abuse, the need for a repeat urine drug screen has not been established.

2. One Q-Tech 21 day rental recovery system is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

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, Continuous-flow cryotherapy.

The Physician Reviewer's decision rationale:

The patient is a 56-year-old female who reported an injury to her low back, thoracic spine, and cervical spine on 12/22/2008 when she is reported to have fallen. She is noted to have undergone a lumbar fusion in 10/2011 and is noted by CT scan to have a compression fracture of the thoracic spine. The Official Disability Guidelines do not recommend the use of cold therapy units for nonsurgical treatment, as there is no documentation that the patient had recently undergone a surgery requiring the use of a cold therapy unit, the requested 21 day rental of a cold therapy unit is not indicated. As such, the request for 1 Q-Tech 21 day rental recovery system is not medically necessary and appropriate.

3. One full leg wrap is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

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, Continuous-flow cryotherapy.

The Physician Reviewer's decision rationale:

The patient is a 56-year-old female who reported an injury to her low back, thoracic spine, and cervical spine on 12/22/2008 when she is reported to have fallen. She is noted to have undergone a lumbar fusion in 10/2011 and is noted by CT scan to have a compression fracture of the thoracic spine. The Official Disability Guidelines do not recommend the use of cold therapy units for nonsurgical treatment, as there is no documentation that the patient had recently undergone a surgery requiring the use of a cold therapy unit, the purchase of a full leg wrap and a universal therapy wrap are not indicated. As such, the request for 1 full leg wrap is not medically necessary and appropriate.

4. One universal therapy wrap is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

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, Continuous-flow cryotherapy.

The Physician Reviewer's decision rationale:

The patient is a 56-year-old female who reported an injury to her low back, thoracic spine, and cervical spine on 12/22/2008 when she is reported to have fallen. She is noted to have undergone a lumbar fusion in 10/2011 and is noted by CT scan to have a compression fracture of the thoracic spine. The Official Disability Guidelines do not recommend the use of cold therapy units for nonsurgical treatment, as there is no documentation that the patient had recently undergone a surgery requiring the use of a cold therapy unit, the purchase of a full leg wrap and a universal therapy wrap are not indicated. As such, the request for 1 universal therapy wrap is not medically necessary and appropriate.

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.

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