
Notice of Independent Medical Review Determination

Dated: 10/29/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	10/14/2011
IMR Application Received:	7/23/2013
MAXIMUS Case Number:	CM13-0002808

- 1) MAXIMUS Federal Services, Inc. has determined the request for six months gym membership **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for lumbar epidural steroid injection at L3-4, and L4-5 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for cushion (unspecified) **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/23/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 six months gym membership **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for lumbar epidural steroid injection at L3-4, and L4-5 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for cushion (unspecified) **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The expert reviewer 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 9, 2013:

"42 year-old male was injured 10/14/11. The mechanism of injury was "Injury occurred while preparing to give an inmate a flu shot, the inmate hit the IW in the chest & pushed him into the rail of the tier 300-400 ft above ground." The carrier has accepted the claim for physical mental, low back, and right hand and fingers. An MRI of the lumbar spine 5/18/12 showed: 1. There is a broad-based central left paracentral disc herniation at L3-4 with slight cranial migration measuring approximately 3mm AP. 2. There is a broad-based central/left paracentral disc herniation at L4-5 with slight cranial migration approx 3mm AP. On 5/02/12 an Electrodiagnostic Study was within normal limits. No surgery has been reported to this reviewer relative to this injury. The requesting provider's medical report dated 6/3/13 stated that the patient complained of persistent low back pain. Objective: Tenderness along the lumbar paraspinal muscles. Diagnosis: Chronic back pain. On 6/18/13 he stated: "requests Gym membership, epidural steroid injection, and cushion."

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 7/24/2013
- Utilization Review Determination from Claims Administrator [REDACTED] dated 7/09/2013
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for six months gym membership :

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), Current Version, Treatment Index, 9th Edition, Gym Memberships. 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 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 10/14/11. The submitted medical records noted low back pain with radiation into the left buttock. The employee's diagnoses included posttraumatic stress disorder, depressive disorder, not otherwise specified, anxiety disorder, not otherwise specified, and lumbosacral sprain with no radiculopathy. Prior treatment has included medications, chiropractic care, massage therapy and acupuncture. A request has been submitted for six months gym membership.

The guidelines note that gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. The guidelines note that gym memberships would not generally be considered medical treatment, and are therefore not covered under these guidelines. Per the submitted medical records, the provider has failed to document evidence of the employee failing with attempts at independent weight loss by documentation of diet and exercise. The requested six months gym membership **is not medically necessary and appropriate.**

2) Regarding the request for lumbar epidural steroid injection at L3-4, and L4-5 :

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 Medical Treatment Guidelines, Epidural Steroid Injections, pg. 46, which is part of the MTUS. 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 10/14/11. The submitted medical records noted low back pain with radiation into the left buttock. The employee's diagnoses included posttraumatic stress disorder, depressive disorder, not otherwise specified, anxiety disorder, not otherwise specified, and lumbosacral sprain with no radiculopathy. Prior treatment has included medications, chiropractic care, massage therapy and acupuncture. A request has been submitted for lumbar epidural steroid injection at L3-4 and L4-5.

The guidelines note that the criteria for the use of epidural steroid injections require that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Per the submitted medical records, electrodiagnostic studies of the bilateral lower extremities revealed no abnormalities, and an MRI of the lumbar spine did not evidence any nerve root involvement to support the requested injections. The requested lumbar epidural steroid injection at L3-4 and L4-5 **is not medically necessary and appropriate.**

3) **Regarding the request cushion (unspecified):**

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), Current Version, Knee and Leg Chapter. 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 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 10/14/11. The submitted medical records noted low back pain with radiation into the left buttock. The employee's diagnoses included posttraumatic stress disorder, depressive disorder, not otherwise specified, anxiety disorder, not otherwise specified, and lumbosacral sprain with no radiculopathy. Prior treatment has included medications, chiropractic care, massage therapy and acupuncture. A request has been submitted for cushion (unspecified).

The guidelines note that durable medical equipment is recommended generally if there is a medical need, and if the device or system meets Medicare's definition of durable medical equipment. The clinical notes lack evidence of the specific cushion that the provider is recommending. Therefore, there is a lack of rationale for the equipment. The requested cushion (unspecified) **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

/srb

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.