

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 9/26/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	3/16/1993
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0002864

- 1) MAXIMUS Federal Services, Inc. has determined the request for Referral to HELP program for increase in ADL **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 Referral to HELP program for increase in ADL **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 9, 2013:

"The patient's date of injury is 03/16/1993. The most recent progress report available for review is dated 07/03/2013. Subjective complaints state "██████ reports pain in back with radiation to the left side, with numbness and tingling down his legs and feet. His pain level is 6-7/10 with medications and limited ADL, walk 30 minutes, sit 15-20 minutes, stand 10-15 minutes, lift less than 10 pounds. He uses modified positions to complete ADLs. Without meds, pain is plus 10, no function. He is unable to squat or bend. He has family who assists him in ADLs. He continues on current pain medications and reports no side-effects and has no abusive behavior". Physical examination identifies "He transfers from sit to stand with stiffness and ambulates with non-antalgic gait. He has functional range of motion and 4/5 strength in extremities. He has 70 degrees flexion and 5 degrees extension of back with tenderness to palpation in cervical and lumbar spinous processes. He has increased tightness in left gluteal region. He has decreased sensation to light touch on the left to right side". Diagnoses is not listed. Current treatment plan includes Norco, Tramadol, Gabapentin, Soma, Fluoxetine, Tylenol, Zolpidem 12.5, "Random urine screen today, referral to HELP for increasing ADL function". An orthopedic surgery report dated October 13, 2010 includes subjective complaints stating "It interferes with his ability to sleep well". The note goes on to include physical examination identifying "Sensation to pinprick was intact in right-lower extremity and diffusely decreased over the left-lower extremity". The notes goes on to state "He has not worked since 2003". The note also goes on to identify "Treatment could include possibly physical therapy for any exacerbations of ongoing use of TENS. He has found that the use of TENS is the most helpful. In addition, the way the treatment has been given by Dr. ████████ office, it appears he has received treatment

three times a month. Recommendation was for physical therapy of chiropractic treatment with a total of twenty-four visits per year for exacerbations, but not on a routine basis".

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 7/24/2013)
- Utilization Review from [REDACTED] (dated 7/9/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for Referral to HELP program for increase in ADL:

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 (2009), pg. 30-32 of 127. The provider did not dispute the guidelines used by the Claims Administrator. 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 March 16, 1993 resulting in back pain. Treatments have included physical therapy, chiropractic care, medication management, massage care and ongoing usage of TENS. The request is for a referral to the HELP program for increase in ADL.

The MTUS Chronic Pain guidelines have set criteria for outpatient pain rehabilitation programs. The medical records of March 8, 2013 document that the employee has met the first through the fourth and sixth criteria of the guidelines. However, there is no documentation in the medical records as to the 5th criterion: motivation to change or what he/she is willing to give up to effect the change. MTUS states "all" criteria must be met for the functional restoration program to be medically necessary. The 5th criterion has not been met, so the request is not in accordance with MTUS. The request for Referral to a HELP program for increase in ADL **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.