
Notice of Independent Medical Review Determination

Dated: 10/11/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 6/14/2011
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003115

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 2 times per week for 8 weeks (lumbar/cervical/shoulder/right knee) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for over the door home cervical traction unit **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for prospective usage of Mobic **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for prospective usage of Prilosec **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/18/2013. 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 physical therapy 2 times per week for 8 weeks (lumbar/cervical/shoulder/right knee) **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for over the door home cervical traction unit **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Error! Reference source not found. is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Error! Reference source not found. 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 18, 2013:

"Primary treating physician's initial evaluation report dated 05/22/13 indicates that in 2005, the claimant began to note the onset of lower back pain, which the claimant attributes to the repetitive twisting required to do as part of the job duties. The claimant states that the cubicle faced forward and the claimant would have to twist in the chair to look back when someone was walking by the cubicle. Additionally, the claimant states that at one point the work involved installing servers which weighed up to 50 pounds and installing cable in the flooring, work stations, etc. In 2006, the symptoms were identified as work related and attributed to the repetitive twisting activities. In 2009, the claimant was moved to a cubicle which was again in a high foot traffic area and the claimant was once again required to do a good deal of twisting. As a result, the claimant noted an increase in the back symptoms. Risk management again suggested rearranging the desk but, again, this was not done. The claimant continued to receive medical care on a periodic basis during periods of exacerbation. The claimant relates that at one point, the claimant was taking up to 15 Motrin per day. The claimant was provided with a new desk but states the claimant felt that the ergonomics were "awkward" and the claimant did not notice significant improvement and continued to experience ongoing pain. In 06/12, the claimant twisted in the chair and experienced a shooting pain in the lower back with radiation into the legs, as well as neck pain. The claimant indicates that on approximately four

occasions in the life the claimant has experienced some very bad headaches. The claimant has fallen on three occasions due to a sudden loss of strength in the right leg and believes that these falls have caused injury to the bilateral shoulders and knees. The claimant had one specific incident in which the claimant was getting out of bed, stepped down on the right leg, and due to excruciating pain, the leg gave out and the claimant fell forward, striking the head against the wall. Additionally, the claimant developed a blood clot in the leg which traveled throughout the body and is presently in the lung. The claimant attributes this to having been bedridden for four days with bronchitis and pneumonia, as well as the severe back pain at one point, the claimant had become addicted to medications and "detoxed" own self. Currently, the claimant complains of lower back pain which is described as sharp, dull, achy, burning, and stabbing. The claimant also complains of bilateral leg, knee pain, and ankle pain, right worse than left, which is described as achy and burning associated with numbness and tingling. The claimant complains of right foot and right 2nd and 3rd toe numbness and tingling, as well as left foot and left 2nd, 3rd, and 4th toe numbness and tingling. The claimant also complains of upper back and bilateral shoulder blade pain which is described as achy and burning associated with tingling. The claimant also complains of neck, head, and right eye pain which are described as achy and burning associated with blurry vision. The claimant also complains of bilateral shoulder pain which is described as sharp, achy, and burning associated with tingling. The claimant also complains of stomach upset, headaches, and irritability. On examination, there is moderate tenderness of the base of the occiput bilaterally, bilateral greater occipital nerves, bilateral paracervical muscles, bilateral upper trapezii,, bilateral levator scapulae, and bilateral rhomboid muscles, as well as at the C7 level. The axial compression test is painful at the base of the neck. Cervical flexion is at 15 degrees, lateral bending is at 12 degrees on the right and 15 degrees on the left, rotation is at 30 degrees on the left and 35 degrees on the left. The deep tendon reflexes in the upper extremities are 1 + in the bilateral biceps and unobtainable in the bilateral triceps and brachioradialis. Regarding the bilateral shoulder, there is tenderness and the resisted flexion/extension does cause discomfort of the shoulders. Resisted flexion/supination of the forearm does produce complaints of pain bilaterally, Shoulder abduction is at 165 degrees on the right and 150 degrees on the left, external rotation is at 70 degrees on both sides, internal rotation is at 75 degrees on the right and 70 degrees on the left, extension is at 20 degrees, flexion is at 90 degrees on both sides, and adduction is at 25 degrees on the right and 20 degrees on the left. The claimant is unable to perform heel walking on the right. The posterior-superior iliac spines are moderately tender bilaterally, with moderate tenderness at the right sciatic notch as well. Lumbar extension is at 10 degrees, lateral bending is at 12 degrees on the right and 10 degrees on the left, and rotation is at 13 degrees on the right and 14 degrees on the left. Straight leg raising in the sitting position is 30/40 degrees and in the supine position is 18/25 degrees. Sciatic nerve root irritability signs are positive bilaterally. There is hypesthesia of the left foot and left 2nd, 3rd, and 4th toes and right foot and right 2nd, and 3rd, toes. Regarding the right knee, there is tenderness of the medial and lateral joint lines, as well as tenderness to the pes anserinus region and femoral condyle. The medial and lateral compartment is positive for tenderness. Patellofemoral compression testing is positive for crepitus. McMurray's test for the medial meniscus is positive. Right knee flexion is at 125 degrees. The provider recommends MRI of the cervical spine, right knee, and both shoulders, Warfarin, referral to pain management, and consultation with a neurologist. The claimant has been instructed to return in four to six weeks."

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 7/25/2013)
- Utilization Review Determination from [REDACTED] (dated 7/18/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for physical therapy 2 times per week for 8 weeks (lumbar/cervical/shoulder/right knee):

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), Physical Medicine, (page note cited), which is a part of Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine, page 98-99, which is a part of MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 6/14/11. The medical records submitted for review indicate treatments have included physical therapy and medication management. The records provided indicate the employee experiences bilateral leg pain, knee pain, ankle pain, upper back pain, bilateral shoulder blade pain, neck pain, stomach upset, headaches, and irritability. The request is for physical therapy 2 times per week for 8 weeks (lumbar/cervical/shoulder/right knee).

MTUS Chronic Pain guidelines for physical therapy recommend 8-10 visits for radiculitis, neuralgia or myalgia. The request for 16 physical therapy visits exceeds guideline recommendations. The request for physical therapy 2 times per week for 8 weeks (lumbar/cervical/shoulder/right knee) **is not medically necessary and appropriate.**

2) Regarding the request for Error! Reference source not found.:

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) (no page cited) which is a part of Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG) (current version), Neck and Upper Back Procedure Summary, (section not cited), a medical treatment guidelines not

part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, page 173-4, part of MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 6/14/11. The medical records submitted for review indicate treatments have included physical therapy and medication management. The records provided indicate the employee experiences bilateral leg pain, knee pain, ankle pain, upper back pain, bilateral shoulder blade pain, neck pain, stomach upset, headaches, and irritability. The request is for over the door home cervical traction unit.

The MTUS ACOEM guidelines state there is no high-grade scientific evidence to support effectiveness of cervical traction. The request is not in accordance with guideline recommendations. The request for over the door home cervical traction unit **is not medically necessary and appropriate.**

3) Regarding the request for Error! Reference source not found.:

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), NSAIDS, (page not cited), which is a part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Pain Interventions and Treatments, pg. 11, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 6/14/11. The medical records submitted for review indicate treatments have included physical therapy and medication management. The records provided indicate the employee experiences bilateral leg pain, knee pain, ankle pain, upper back pain, bilateral shoulder blade pain, neck pain, stomach upset, headaches, and irritability. The request is for a **Error! Reference source not found.**

MTUS Chronic Pain guidelines require the physician to use clinical judgment in determining the frequency, intensity and duration of treatment. The records provided indicate the physician used clinical judgment when he determined that Mobic (a two month supply) was necessary. The physician did not request or state that a 3-month supply was needed on the reviewed 7/3/13 report. The Utilization Review dated 7/18/13 authorized a two month supply of Mobic 7.5 mg indicating that this request was certified not modified. The request for a **Error! Reference source not found. is not medically necessary and appropriate.**

4) Regarding the request for **Error! Reference source not found.**:

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), NSAIDS, (page not cited), which is a part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines (2009), Pain Interventions and Treatments, pg. 11, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 6/14/11. The medical records submitted for review indicate treatments have included physical therapy and medication management. The records provided indicate the employee experiences bilateral leg pain, knee pain, ankle pain, upper back pain, bilateral shoulder blade pain, neck pain, stomach upset, headaches, and irritability. The request is for prospective usage of Prilosec.

MTUS Chronic Pain guidelines require the physician to use clinical judgment in determining the frequency, intensity and duration of treatment. The records provided indicate the physician used clinical judgment when he determined that Prilosec (a two month supply) was necessary. The physician did not request or state that a 3-month supply was needed on the reviewed 7/3/13 report. The Utilization Review dated 7/18/13 authorized a two month supply of Prilosec 20mg indicating that this request was certified not modified. The request for a **Error! Reference source not found. 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

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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.