

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/15/2013
Date of Injury: 7/30/2009
IMR Application Received: 7/25/2013
MAXIMUS Case Number: CM13-0003481

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 Preventive Medicine and Occupational Medicine 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:

All four pages of medical, insurance, and administrative records provided were reviewed. The applicant, Mr. [REDACTED] has filed a claim for chronic neck and low back pain reportedly associated with an industrial injury of July 30, 2009.

Thus far, he has been treated with the following: Attorney representation and prior three-level lumbar fusion surgery at L3-L4, L4-L5, and L5-S1 on July 18, 2013.

The sole note on file is a July 15, 2013 utilization reviewer report denying authorization for a cold therapy unit.

IMR DECISION(S) AND RATIONALE(S)

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

1. Cold Therapy Unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 12, (revised), PDF version, pg 161, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) pg. 161, which is part of the MTUS. The Physician Reviewer also cited the ACOEM V.3, Chronic Pain, General Principles of Treatment, Allied Health Professionals, Allied health therapies Medical Treatment Guidelines, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM guidelines indicate that at home local applications of heat and cold, are as effective as those performed by a therapist or by implication, high tech devices. The guidelines do not endorse usage of high-tech devices for delivering heat and cold therapy for treatment of any chronic pain condition. In this case, no clinical progress notes were attached to the request for authorization to try and make a case for a variance from the guidelines. Therefore, the request remains non-certified, on independent medical review. **The request for cold therapy unit is not medically necessary and appropriate.**

/pas

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.

[REDACTED]
[REDACTED]
[REDACTED]

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