

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/17/2013
Date of Injury:	7/28/2002
IMR Application Received:	7/30/2013
MAXIMUS Case Number:	CM13-0005142

- 1) MAXIMUS Federal Services, Inc. has determined the request for the purchase of a cold therapy polar care **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a shower chair **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/30/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/13/2013. 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 the purchase of a cold therapy polar care **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a shower chair **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 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 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.

Expert Reviewer Case Summary:

Patient presented with a date of injury of July 28, 2002. The patient presented with lumbar pain and in the right leg had numbness and tingling. Patient had guarding and spasm and loss of range of motion in the lumbar spine. Diagnosis was muscular ligament sprain and strain lumbar spine , DDD, foraminal stenosis and radiculopathy. Treatment has included activity modification physical therapy, chiro, ESI, medications. The patient is approved for lumbar fusion.

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 of Independent Medical Review
- Utilization Review Determination Bunch Care Solutions
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for the purchase of a cold therapy polar care:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), which is not part of the MTUS, and the Post-Surgical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

ODG does not recommend cold therapy units after spine surgery. Although application of cold may have an analgesic effect, no specific brand or proprietary device is required for cold application. **The request for the purchase of a cold therapy polar care is not medically necessary and appropriate**

2) Regarding the request for shower chair:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Post Surgical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

Medical records do not indicate the need for the shower chair. The surgeon has not cited specific reasons for the chair. There are no standard guidelines or general medical practices for the chair as well. There are no medical records provided that indicate the rationale for the chair and there are no general practices for the chair. **The request for a shower chair 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/bh

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.