

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: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	9/27/2012
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005515

- 1) MAXIMUS Federal Services, Inc. has determined the request for an **X-Force stimulator with supplies is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **Solar-Care FIR heating system is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **Kronos L/S pneumatic brace is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/16/2013. 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 an **X-Force stimulator with supplies** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **Solar-Care FIR heating system** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **Kronos L/S pneumatic brace** 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 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 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:

All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented employee who has filed a claim for chronic low back pain reportedly associated with industrial injury of September 27, 2012.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers and various specialties; and extensive periods of time off work.

The applicant last worked on March 30, 2013.

Specifically reviewed is a July 10, 2013, utilization review determination of partially certifying a request for a TENS unit to a one-month trial of the same; an MRI of lumbar spine of July 11, 2013, notable for a 6 mm disc protrusion at L5-S1; unspecified amounts of extracorporeal shockwave therapy.

The applicant's attorney appealed on July 18, 2013.

A recent clinical progress note of June 17, 2013, is notable for comments that the applicant is a former packer. The applicant presents with low back pain intermittently radiating to low back. Right lower extremity strength ranges from 4-5/5. The applicant is obese with a BMI of 33. The patient was asked to obtain extracorporeal shockwave

therapy and employ both oral and topical analgesics for pain relief while remaining off of work, on total temporary disability.

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
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for an X-Force stimulator with supplies:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy, page 114-116, which is part of the MTUS, and the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Criteria for the use of TENS, page 116, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines, page 116, indicate that TENS units are tepidly endorsed, on a trial basis, in those individuals with chronic intractable pain of greater than three months' duration in whom other appropriate pain modalities, including analgesic medications, have been tried and/or failed. The records submitted for review indicate do not document clear evidence of oral analgesic medication failure. The employee was previously issued partial certification for a one-month trial of a TENS unit. **The request for an X-Force stimulator with supplies is not medically necessary and appropriate.**

2) Regarding the request for a Solar-Care FIR heating system:

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

The Claims Administrator based its decision on the ODG, (2013), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Table 12-5, Methods of Symptom Control for Low Back Complaints, page 299, and Physical Methods, page 300, which is part of the MTUS and the ACOEM, 3rd Edition (online), Chronic Pain, General Principles of Treatment, Allied Health Professionals, Allied Health Therapies, which is not part of the MTUS.

Rationale for the Decision:

As noted in the MTUS/ACOEM Guidelines, physical methods such as diathermy have no proven efficacy in treating acute low back complaints. The proposed Solar-Care Heating System is a form of diathermy. The guidelines further support at home applications of heat and cold as opposed to high-tech means of delivering heat and cold. This is echoed by the third edition ACOEM Guidelines, which do not support or endorse high-tech appliances to deliver heat therapy. The records submitted for review do not indicate that the employee has tried an at-home application of heat or cold therapy prior to the request for a high tech heating system. **The request for a Solar-Care FIR heating system is not medically necessary and appropriate.**

3) Regarding the request for a Kronos L/S pneumatic brace:

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

The Claims Administrator based its decision on the ODG 2013, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Physical Methods, page 301, which is part of the MTUS.

Rationale for the Decision:

As noted in the MTUS/ACOEM Guidelines, lumbar supports have no lasting benefit beyond the acute phase, for symptom relief purposes. The records submitted for review indicate that the employee was treated for chronic low back pain. The use of lumbar supports is not indicated in the chronic pain context present here. **The request for a Kronos L/S pneumatic brace 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

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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.