

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/26/2013
Date of Injury:	6/28/2012
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0006892

- 1) MAXIMUS Federal Services, Inc. has determined the request for Interspec IF II Unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Monthly Supplies **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for LSO Brace **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Home Exercise Kit **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/16/2013. 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 Interspec IF II Unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Monthly Supplies **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for LSO Brace **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for Home Exercise Kit **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, Ms. [REDACTED], is a represented 47-year-old former [REDACTED] [REDACTED] janitor who has filed a claim for a low back pain and depression, reportedly associated with an industrial injury of June 28, 2012.

Thus far, she has been treated with the following: Analgesic medications; unspecified amounts of physical therapy; and extensive periods of time off from work.

The applicant last worked in June 2012.

In a utilization review report of July 26, 2013, the claims administrator denied an interferential therapy unit and a lumbar support.

In a mental health note of June 27, 2013, the applicant was given a prescription for Desyrel for insomnia. She was reportedly not using any analgesic medications at that time.

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 Interspec IF II Unit:

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, pg 118, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 120 of 127, which is a part of the MTUS.

Rationale for the Decision:

As noted on page 120 of the MTUS Chronic Pain Medical Treatment Guidelines, interferential stimulation is, at best, tepidly endorsed in the treatment of pain in those individuals in whom pain is ineffectively controlled owing to diminished medication efficacy, issues of medication side effects, and/or history of substance abuse that would make provision of analgesic medications unwise. After a review of the medical records provided, in this case, there is no history of substance abuse, medication intolerance, medication inefficacy, or medication side effects that would make the employee's case for usage of the interferential therapy device. There is no evidence of a prior successful 1-month trial of said interventional therapy device. **The request for Interspec IF II Unit is not medically necessary and appropriate.**

2) Regarding the request for Monthly Supplies:

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

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) Regarding the request for LSO 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 MTUS, ACOEM Guidelines Chapter 12, pg 301, which is a part of the MTUS.

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

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, lumbar supports have not been shown to have any lasting benefit outside of the acute phase of symptom relief. After a review of the medical records provided, in this case, lumbar supports are not indicated in the chronic pain context here. Further usage of lumbar support, at this late day, would only serve to promote immobility and disuse, neither of which are to be encouraged. **The request for an LSO Brace is not medically necessary and appropriate.**

4) Regarding the request for Home Exercise Kit:

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 ACOEM Guidelines, Chapter 12, pg 299, table 12-5, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg. 46-47, which is a part of the MTUS.

Rationale for the Decision:

As noted on pages 46 and 47 in the MTUS Chronic Pain Medical Treatment Guidelines, there is no sufficient evidence to support the recommendation of any specific medication regimen over another. After a review of the medical records provided, in this case, it is not clearly stated why the employee cannot perform home exercises independently. It is not clearly stated what the exercise kit represents. It is further noted that the MTUS-adopted ACOEM Guidelines in Chapter 5 suggest that remaining active, maintaining appropriate levels of activity, adherence to exercise regimens, etc., are considered matters of employee responsibility as opposed to medical necessity. It is noted that, as with the other requests, no compelling rationale or narrative accompanies the request for authorization. **The request for a Home Exercise Kit 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.