MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/2/2013

Employee:	
Claim Number:	
Date of UR Decision:	8/5/2013
Date of Injury:	12/15/2012
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0008659

1) MAXIMUS Federal Services, Inc. has determined the request for **work conditioning/functional restoration per QFCE (unspecified frequency/duration) is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **shockwave therapy (unspecified frequency/duration) is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **follow-up with internal medicine is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. 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 **work conditioning/functional restoration per QFCE (unspecified frequency/duration)** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **shockwave therapy (unspecified frequency/duration)** is not **medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **follow-up with internal medicine** is **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:
All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented 52-year-old machinist who has filed a claim for chronic low back pain reportedly associated with an industrial injury of December 15, 2012.

Thus far, he has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; unspecified amounts of chiropractic manipulative therapy; unspecified amounts of physical therapy; unspecified amounts of acupuncture; extensive periods of time off work, on total temporary disability; normal electrodiagnostic testing of the lumbar spine, bilateral lower extremities on March 14, 2013; and an MRI of the lumbar spine of March 13, 2013, notable for low-grade disc bulges and degenerative changes of uncertain clinical significance.

In a utilization review report of August 5, 2013, the claims administrator denied pain management referral for an epidural steroid injection, denied extracorporeal shockwave therapy, and denied request for work conditioning/functional restoration, shockwave therapy, and a follow-up visit with internal medicine. A referral to pain management to consider an epidural steroid injection, conversely, was certified. It is noted that the

utilization review decision is very difficult to read. It does not clearly state what services are certified and what services are non-certified.

In a July 30, 2013, progress note, the applicant is asked to remain off work, on total temporary disability, pursue a pain management referral for an epidural steroid injection, and follow up with internal medicine. The applicant reports 7/10 pain, it is further stated.

An earlier progress note of April 16, 2013, is notable for comments that the applicant is issued a prescription for Coreg for hypertension. The applicant's blood pressure is 141/94. The applicant is also given Prilosec for reported gastritis.

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 work conditioning/functional restoration per QFCE (unspecified frequency/duration):**

   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, which is part of the MTUS.

   The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, 8 C.C.R. §§9792.20 – 9792.26 MTUS (Effective July 18, 2009) Page 32 of 127, which is part of the MTUS. The Expert Reviewer also based his/her decision on the Official Disability Guidelines (ODG), Work Conditioning, which is not part of the MTUS.

   Rationale for the Decision:
   No treatment frequency or treatment duration was attached to the request for authorization or application for independent medical review. Furthermore, the request of functional restoration program versus work conditioning program is generally mutually exclusive. That is, the employee should either pursue functional restoration or work conditioning if the employee is in fact a candidate for either program. Since the independent medical review process does not permit the reviewer with an opportunity to issue a conditional certification or qualified certification, I cannot specifically recommend either program over the other or provide treatment frequency or treatment duration. It is further noted that the employee does not clearly meet criteria for either program. For example, criteria for pursuit of functional restoration program include evidence that an adequate and thorough precursor evaluation has been completed, that previous means of treating chronic pain have been unsuccessful and there is an absence

of other options likely to result in significant clinical improvement. In this case, however, the employee is undergoing an epidural steroid injection. It is possible that this could result in further improvement, potentially obviating the need for the functional restoration program. It is further noted that it does not clearly state that the employee is motivated to get off total temporary disability and return to some form of work.

Similarly, criteria set forth for pursuit of work conditioning on page 125 of the MTUS Chronic Pain Medical Treatment Guidelines include the fact that the employee should not be a candidate for treatments that will be clearly warranted to improve function. Again, the employee is receiving an epidural steroid injection that could result in an improvement in function. Pursuit of work conditioning is likewise not indicated in this context, especially in an unspecified rate, frequency, and overall amount. **The request for work conditioning/ functional restoration per QFCE (unspecified frequency/duration) is not medically necessary and appropriate.**

2) **Regarding the request for shockwave therapy (unspecified frequency/duration):**

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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), which is part of the MTUS. The Expert Reviewer also based his/her decision on the Official Disability Guidelines (ODG), Work Conditioning, which is not part of the MTUS.

Rationale for the Decision:
The MTUS does not specifically address the topic of extracorporeal shockwave therapy for the lumbar spine. As noted in the ODG, Low Back Chapter Shockwave Therapy topic, extracorporeal shockwave therapy has not been deemed effective in treating low back pain. In this case, the employee has been receiving numerous other treatments they do carry more favorable recommendations, including a proposed epidural steroid injection. It is further noted that the MTUS-adopted ACOEM Guidelines in Chapter 12 suggest, by analogy, that ultrasound has no proven efficacy in treating low back complaints. Extracorporeal shockwave therapy is a form of ultrasound. **The request for shockwave therapy (unspecified frequency/duration)** is not **medically necessary and appropriate.**

3) **Regarding the request for follow-up with internal medicine:**

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 medicatal Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Page 1 of 127, which is part of the MTUS.

Rationale for the Decision:
As noted on page 1 of the MTUS Chronic Pain Medical Treatment Guidelines, the presence of persistent complaints does make a compelling argument for a specialist evaluation. In this case, the employee does carry a diagnosis of hypertension for which the employee is receiving Coreg, a blood pressure-lowering medication, from an internist. Following up with that internist is indicated. Accordingly, the original utilization review decision is overturned. **The request for follow-up with internal medicine** is **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

/cmol

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.