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## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: Select Date

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/1/2013  
Date of Injury: 3/27/2011  
IMR Application Received: 8/8/2013  
MAXIMUS Case Number: CM13-0009052

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 Physical Medicine and Rehabilitation, 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:

The patient is a 70-year-old male who reported an injury on 03/27/2011 due to closing a stuck gate that caused strain to his low back. An MRI revealed numerous masses in the vertebral bodies, encroachment on the left L1-2 neural foramina with thickening of the nerve root. The patient was treated with regular back exercises, medications, and massage. The patient complained of low back pain with stiffness of the left lower extremity. Physical findings included positive midline lumbosacral tenderness and positive lumbosacral paraspinal stiffness. The patient had positive sciatic notch tenderness to the left and decreased deep tendon reflexes to the bilateral lower extremities. The patient was later diagnosed with lung and brain cancer and received radiation therapy. The patient's diagnosis included a compression fracture. The patient's treatment plan included continuation of radiation therapy, chemotherapy, and medication management.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. Lift chair is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Knee and Leg Chapter, Durable Medical Equipment, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The requested lift chair is not medically necessary or appropriate. The patient does continue to have low back pain with radicular symptoms. California Medical Treatment Guidelines do not address this request. The Official Disability Guidelines recommend durable medical equipment can withstand repeated use, is customarily and primarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in the patient's home. While a lift chair would be appropriate for use in the patient's home and could stand repeated use, this type of equipment is not primarily and customarily used to serve a medical purpose. Also, this type of equipment would be useful to a person in the absence of illness and injury. The clinical documentation submitted for review did not provide any specific limitations that would require the need for a lift chair. There is no documentation that the patient has an inability to rise from a chair independently. **The request for a lift chair is not medically necessary and appropriate.**

/skf

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]

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