

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/29/2013
Date of Injury:	12/2/2012
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009721

- 1) MAXIMUS Federal Services, Inc. has determined the request for **spin bike for homeuse, purchase is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **foam roller, purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **healing pad, purchase is not 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 7/29/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 **spin bike for homeuse, purchase is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **foam roller, purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **healing pad, purchase 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 Internal 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:

The clamant sustained a work- related low back injury on 12/02/12. He continues with low back pain with radiation to the right lower extremity. He reports associated numbness and tingling to the level of the leg to thigh. The pain is rated 7/10 with medical therapy and is aggravated by standing, walking, bending, twisting, turning and rotation. MRI of the lumbar spine without contrast obtained 12/15/12 revealed moderate loss of disc space height with mild disc desiccation at L1-L2. A 2mm disc bulge is eccentric toward the inferior recess of the left neural foramina which is mildly narrowed. At L4-L5, there is moderate dessication with a 2mm annular disc bulge that abuts the ventral margin of the thecal sac. There is mild foraminal narrowing. There is severe right neural foraminal stenosis and impingement of the right foraminal L4 nerve and at L5-S1 there is mild bilateral facet arthropathy. He continues with medical therapy, physical therapy, and use of a TENS. The treating provider has recommended transforaminal epidural steroid injections, continued physical therapy, purchase of a spin bike for home use, purchase of a foam roller and purchase of a heating pad.

### 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 spin bike for homeuse, purchase :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CMS Medicare Benefit Policy Manual, Chapter 15, Section 110.1, which is not part of the MTUS.

The Expert 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 CMS Medicare/Blue Cross of California Medical Policy, Durable Medical Equipment.

Rationale for the Decision:

The guidelines from CMS Medicare/Blue Cross of California Medical Durable Medical Equipment note that durable medical equipment is defined as an item which provides therapeutic benefits or enables the member to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions or illnesses. There is no specific documentation that the requested spin bike is necessary to improve the employees back condition. The employee has participated in physical therapy and the spin bike is not specifically required to ensure subjective, objective and functional benefit to the condition. **The request for spin bike for homeuse purchase is not medically necessary and appropriate.**

**2) Regarding the request for foam roller, purchase :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the CMS Medicare Benefit Policy Manual, Chapter 15, Section 110.1, which is not part of the MTUS.

The Expert 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 CMS Medicare/Blue Cross of California Medical Policy, Durable Medical Equipment.

Rationale for the Decision:

The guidelines from CMS Medicare/Blue Cross of California Medical Durable Medical Equipment note that durable medical equipment is defined as an item which provides therapeutic benefits or enables the member to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions or illnesses. There is no specific documentation that the requested foam is necessary to improve the employees back condition. The employee has participated in physical therapy and the foam roller is not specifically required to

ensure subjective, objective and functional benefit to the condition. **The request for foam roller purchase is not medically necessary and appropriate.**

**3) Regarding the request for healing pad, purchase :**

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Low Back Procedure Summary, which is not part of the MTUS.

The Expert 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 Medscape Internal Medicine Treatment of Low Back Pain, 2012.

Rationale for the Decision:

Per Medscape Internal Medicine, heat therapy is recommended as an option in the treatment of low back pain. The documentation indicates that the employee found some benefit with the use of a heating pad however there is no objective documentation of sustained pain relief with heat therapy. In addition, there was no specific documentation of improvement in function with the specifically requested heating pad. **The request for healing pad purchase 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, 18<sup>th</sup> 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.