

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/17/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/15/2013
Date of Injury: 6/17/2006
IMR Application Received: 8/20/2013
MAXIMUS Case Number: CM13-0014390

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 Psychiatrist, has a subspecialty in Child & Adolescent Psychiatrist 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

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 68-year-old male who reported an injury on 06/17/2006, with the mechanism of injury stated to be that the patient was carrying a box of books, lost his balance as he was walking upstairs and fell backwards. The patient was noted to have spasms in the lumbar region of his back as well as the cervical spine. The patient was noted to have tenderness of the cervical and paraspinal muscles and the spinous process. The patient was noted to complain of pain to the bilateral shoulders. The diagnoses were stated to include cervical radiculopathy, lumbar radiculopathy, lumbago, sprain of the neck, disc disorder, rotator cuff tear of the bilateral shoulders, bilateral shoulder impingement syndrome and right wrist TFCC tear. The request was made for alendronate 70 mg #4.

IMR DECISION(S) AND RATIONALE(S)

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

1. Retrospective Alendronate 70mg number four (4) is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Alendronate, page 13, & Bisphosphonates, page 25, which are part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS Guidelines recommend Alendronate, which is Fosamax, for the treatment of bone resorption (osteoporosis) in patients with CRPS Type I. The medication is not indicated for other chronic pain conditions. The clinical documentation submitted for review failed to provide that the employee had a condition that would cause osteoporosis and failed to provide

that the employee had CRPS Type I to support the necessity for the medication. Given the above, the retrospective request for alendronate 70 mg #4 is not medically necessary or medically appropriate. **The request for retrospective Alendronate 70mg number four (4) is not medically necessary and appropriate.**

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]

CM13-0014390