
Notice of Independent Medical Review Determination

Dated: 9/25/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/1/2013

12/19/1997

7/15/2013

CM13-0001468

- 1) MAXIMUS Federal Services, Inc. has determined the request for Soma **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a therapeutic mattress **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/15/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/17/2013. A decision has been made for each of the treatment and/or services that were in dispute:

MAXIMUS Federal Services, Inc. has determined the request for Soma is not medically necessary and appropriate.

MAXIMUS Federal Services, Inc. has determined the request for a therapeutic mattress 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 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 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 1, 2013:

“The patient is a 68 year old female with a date of injury of 12/19/1997. This review is for the consideration of the requested 1 prescription for Soma, 1 prescription for Mobic, 1 prescription for Prilosec, 1 referral for pain management, 1 therapeutic mattress, and 12 additional home health care visits.”

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 for Independent Medical Review (dated 7/15/2013)
- Utilization Review from [REDACTED] (dated 7/1/2013)
- Medical Records from [REDACTED] (dated 7/27/12-7/30/12)
- Medical Records from [REDACTED] (dated 8/3/12-4/15/13)
- Medical Records from [REDACTED] (dated 11/28/12-4/30/13)
- Medical Records from [REDACTED] (dated 1/25/13)
- Medical Records from [REDACTED] (dated 1/29/13)
- Medical Records from [REDACTED] (dated 4/9/13-4/24/13)
- Medical Records from [REDACTED] (dated 4/30/13)
- Medical Records from [REDACTED] (dated 4/30/13)
- Medical Records from [REDACTED] (dated 5/3/13-5/17/13)

- Chronic Pain Medical Treatment Guidelines (May, 2009) Part 2, Pain Interventions and Treatments pg. 19, 53

1) Regarding the request for Soma:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 19, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on December 19, 1997 to the lower back. The medical records provided and reviewed indicate treatments have included a spinal cord stimulator, physical therapy, and medication management. The request is for a prescription for Soma.

MTUS Chronic Pain guidelines do not recommend long-term use of Soma; Soma is recommended for the short-term management of spasticity. The medical records provided for review indicate that the employee has been taking Soma for a prolonged period of time, and there is no documentation of the efficacy or functional improvement derived from its use. The request for a prescription for Soma **is not medically necessary and appropriate.**

2) Regarding the request for a therapeutic mattress:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) Lumbar & Thoracic (Acute & Chronic), a Medical Treatment Guideline (MTG) which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer stated MTUS does not address the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on December 19, 1997 to the lower back. The medical records provided and reviewed indicate treatments have included a spinal cord stimulator, physical therapy, and medication management. The request is for a therapeutic mattress.

The Official Disability Guidelines indicate that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. The medical records provided for review documented that the employee had a recent surgery to remove a malfunctioning thoracic spinal cord

stimulator, however, there is no documentation relating to issues of insomnia which would be related to mattress choice. The request for a therapeutic mattress **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.