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**Notice of Independent Medical Review Determination**

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/10/2013  
Date of Injury: 5/11/2012  
IMR Application Received: 7/17/2013  
MAXIMUS Case Number: CM13-0001890

- 1) MAXIMUS Federal Services, Inc. has determined the request for HELP interdisciplinary reassessment **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/17/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/20/2013. 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 HELP interdisciplinary reassessment **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 10, 2013:

“Patient is a 51 year old (DOB: 11/23/61) female who on 05/11/12 while at work, fell backwards over a cement parking block and landed on her hands, back of her head and back. The Hand (Right), Soft Tissue Neck, Shoulders (Both) and Wrists (Both) are accepted by the carrier.”

### **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 (received 7/17/2013)
- Utilization Review Determination from [REDACTED] (dated 7/10/2013)
- Medical Records provided by the claims administrator
- Medical Treatment Utilization Schedule

### **1) Regarding the request for HELP interdisciplinary reassessment:**

#### 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, (2009), Chronic pain programs (functional restoration programs), pages 30-32, 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 5/11/12. The submitted and reviewed medical records documentation pain in the neck, bilateral hands and arms, right lower extremity, bilateral shoulder blades, and throughout the back. The records indicate diagnoses include: bilateral upper extremity CRPS, low back pain with right lower extremity weakness, cervical radiculopathy, scapulargia, severe depression, anxiety, sleep disorder, absent libido, and deconditioning. Prior treatment has included braces/casts, massage, trigger point injections, acupuncture, physical therapy, and medications. A request has been submitted for HELP interdisciplinary reassessment.

MTUS Chronic Pain guidelines note that outpatient pain rehabilitation may be considered medically necessary when an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement. The guidelines further note that treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The submitted and reviewed medical records indicate that the employee has already completed a six week course of comprehensive functional restoration program called HELP. Only modest functional gains were made, and the employee continues to depend on opiates. The requested HELP interdisciplinary reassessment **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  
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Oakland, CA 94612

/srb

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.