

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/23/2013

[REDACTED]

[REDACTED]

|                           |              |
|---------------------------|--------------|
| Employee:                 | [REDACTED]   |
| Claim Number:             | [REDACTED]   |
| Date of UR Decision:      | 7/3/2013     |
| Date of Injury:           | 5/17/2012    |
| IMR Application Received: | 7/29/2013    |
| MAXIMUS Case Number:      | CM13-0003738 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for refill of medications (unspecified) **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/7/2013. 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 refill of medications (unspecified) **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The 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 Family Practice 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 3, 2013:

“The claimant is a [REDACTED] who has filed a claim for bilateral wrist pain, neck pain, low back pain, and mid back pain, reportedly associated with an industrial injury of 05/17/12. Thus far, she has been treated with analgesic medications; transfer of care to and from various providers in various specialties; unspecified amounts of chiropractic manipulative therapy; and extensive periods of time off work.”

### **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 7/29/13)
- Utilization Review Determination from [REDACTED] (dated 7/5/13)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request** refill of medications (unspecified):

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

The Claims Administrator did not provide any evidence-based guidelines for their decision. The Expert Reviewer found that MTUS does not apply because there is no specific medication name to review.

Rationale for the Decision:

The employee sustained an industrial related injury on 5/17/12. The records provided for review indicate bilateral wrist pain, neck pain, low back pain, and mid back pain. The records indicate treatment has included: analgesic medications, unspecified amounts of chiropractic manipulative therapy, and extensive periods of time off work.

The Medical Treatment and ACOEM guidelines do not apply since there is no specific name of the medication(s) to refill. The records submitted for review from the requesting physician in June 2013 do not indicate the name of medications to be refilled. The request for refill of medications (unspecified) **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, 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.