

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

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- 1) MAXIMUS Federal Services, Inc. has determined the requested continued treatment with Dr. [REDACTED] in six weeks **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested physical therapy two (2) times a week for six (6) weeks for the cervical and lumbar spine **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/13/2013 disputing the Utilization Review Denial dated 6/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/13/2013. 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 continued treatment with Dr. [REDACTED] in six weeks **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested physical therapy two (2) times a week for six (6) weeks for the cervical and lumbar spine **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 June 3, 2013.

"Mr. [REDACTED] Is a 30 year-old gentleman with an accepted claim of an injury to multiple body parts secondary to falling on his motorcycle on January 17, 2013, while working for the [REDACTED].

"DISCUSSION: Received May 23, 2013 is a Primary Treating Physician's Progress Report (PR-2) regarding [REDACTED] from [REDACTED], PA-C and [REDACTED], M.D. date of service May 21, 2013.

"In Dr. [REDACTED] report, he notes that Mr. [REDACTED] underwent a left L4-5 epidural steroid injection with Dr. [REDACTED] and states, "...the injection has not helped much, and he has not noticed any improvement, although he had his injection yesterday." Continued complaints lumbar spine and neck pain are noted. On examination of the cervical and lumbar spine there is tenderness and stiff range of motion with subjective symptoms of left radicular pain in the C7 dermatome. Tenderness is noted in the lumbar spine. An MRI of the cervical spine from May 7, 2013 is mentioned.

"The assessment includes:

1. Cervical Stenosis.
2. Cervicalgia.
3. Left Arm Pain.

4. Lumbago.
- 5 .Lumbar Degenerative Disk Disease.

“The treatment plan is for Mr. [REDACTED] to continue conservative treatment and a prescription for Arthrotec 50/200 mg quantity #60 with 1 refill given and he is to continue treatment and follow-up care with Dr. [REDACTED] in 6 weeks. A request for physical therapy twice a week for 6 weeks for the cervical spine and lumbar spine is also included. The work status remains temporarily totally disabled.”

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 6/13/13)
- Treatment Modification Letter by [REDACTED] to Provider (dated 6/3/13)
- Treatment Modification Letter by [REDACTED] to Vendor (dated 6/3/13)
- Multiple Treatment Modification Letter by [REDACTED] (not applicable to the disputed treatment) (dated 2/1/13 – 5/29/13)
- Medical Records from [REDACTED] (dated 3/12/13 – 7/11/13)
- Procedure Report from [REDACTED] (dated 5/20/13)
- Medical Records from [REDACTED] (dated 4/23/13 – 5/21/13)
- Medical Records from [REDACTED] (dated 1/17/13 – 4/18/13)
- MRI Lumbar Spine from [REDACTED] (dated 2/28/13)
- MRI Right Shoulder with Contrast from [REDACTED] (dated 5/7/13)
- Fluoro Guidance Needle Placement for MRI from [REDACTED] (dated 5/7/13)
- MRI Cervical Spine from [REDACTED] (5/7/13)
- Medical Records from [REDACTED] (dated 2/26/13 – 4/30/13)
- Medical Records from [REDACTED] (dated 1/17/13)
- Official Disability Guidelines (ODG) (updated 2013), Low Back - Lumbar and Thoracic and Neck and Upper Back Chapters, Physical Therapy Sections

1) Regarding the request for continued treatment with Dr. [REDACTED] Spine Physician in six weeks:

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

The Claims Administrator did not base its decision on any evidence based guidelines. The provider did not provide any evidence based guidelines. The Expert Reviewer found no section of the Medical Treatment Utilization Schedule (MTUS) applicable and relevant. The Expert Reviewer found the Official Disability Guidelines (2009), which is a Medical Treatment Guideline (MTG) not in the MTUS and is the most recent version of the MTG, was applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 1/17/13, employee was seen in the emergency department after a motorcycle incident at work with knee, shoulder, back and toe pains. Initial conservative treatment included physical therapy and oral analgesia. MRI of the lumbar spine revealed annular tear at L3-L4 and L4-L5. L4-5 epidural steroid injection on 5/20/13 did not provide relief. A prescription for Arthrotec 50/200 mg, follow-up care and continued treatment with Dr. [REDACTED] a physician specializing in Physical Medicine and Rehabilitation of the spine, and physical therapy were requested.

ODG's state that evaluation and management of outpatient visits to the offices of medical doctor(s) plays a critical role in the proper diagnosis and return to work of an injured worker. The determination of necessity for an office visit requires individualized case review and assessment. Ongoing care is within the standard of care. The request for continued treatment with Dr. [REDACTED] in six weeks **is medically necessary and appropriate.**

2) Regarding the request for physical therapy two (2) times a week for six (6) weeks for the cervical and lumbar spine:

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) (updated 2013), Low Back - Lumbar and Thoracic and Neck and Upper Back Chapters, Physical Therapy Sections, which is a Medical Treatment Guideline (MTG) not in the Medical Treatment Utilization Schedule and is the most recent version of the MTG. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS applicable and relevant. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance

Rationale for the Decision:

On 1/17/13, employee was seen in the emergency department after a motorcycle incident at work with knee, shoulder, back and toe pains. Initial conservative treatment included physical therapy and oral analgesia. MRI of the lumbar spine revealed annular tear at L3-L4 and L4-L5. L4-5 epidural steroid injection on 5/20/13 did not provide relief. A prescription for Arthrotec 50/200 mg, follow-up care and continued treatment with Dr. [REDACTED] a physician specializing in Physical Medicine and Rehabilitation of the spine, and physical therapy were requested.

The MTUS does not address the number of physical therapy visits recommended. ODG's state that "patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy)". Physical therapy is typically approved in six visit increments to allow for a reasonable amount of treatment to be rendered and objectively documented before additional therapy is certified. The requested physical therapy two (2) times a week for six (6) weeks for the cervical and lumbar spine **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

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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.