

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested 12 physical therapy sessions for the cervical spine, lumbar spine and the right shoulder **are not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/14/2013 disputing the Utilization Review Denial dated 5/30/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/14/2013. 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 requested 12 physical therapy sessions for the cervical spine, lumbar spine and the right shoulder **are not medically necessary and appropriate.**

Medical Qualifications of the Professional 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 professional 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 May 30, 2013.

“The patient is a 40-year-old female who injured her neck, shoulder, and back on 1/6/13 when she was kicked in the stomach by a patient. The patient is diagnosed with cervical spine sprain/strain with myofasciitis, right hips sprain/strain, right sided chest wall contusion versus rib fracture, right shoulder sprain/strain with myofasciitis, and lumbar spine sprain/strain with underlying generative disease. A request for additional physical therapy visits has been made. On 1/24/13 physical therapy evaluation, the patient was recommended with six physical therapy visits. On 1/29/13 physical therapy progress report, the patient reported improved mobility and decreased neck pain after three sessions. MRI of the cervical spine by Dr. [REDACTED] dated 2/8/13 showed C4-5 and C5-6 degenerative changes. MRI of the lumbar spine was also done by Dr [REDACTED] on 2/8/13 which showed multilevel degenerative changes. The recent medical record dated 5/15/13 indicates that the patient continues to experience pain in the neck, right shoulder, ribs, and low back. On examination, there is tenderness over the upper trapezius in the right shoulder, and right rib cage/chest wall. There is positive Neer’s provocative testing in the right shoulder. Tenderness is also noted over the right iliac crest area in the lumbar spine. X-rays cervical spine showed straightening of the normal cervical lordosis. Radiographs of the bilateral shoulders showed normal quality of bone, no acute fractures or dislocations. There is type II acromion morphology on both sides. Bilateral rib series did not show any distinct fractures lines. Radiographs of lumbar spine showed maintained lumbar lordosis, disc space narrowing at L4-5 and L5-S1. Facet arthropathy is seen form L3-S1. While continued PT may be considered, there is lack of information regarding the number of completed sessions to date and the patient’s functional response....”

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 6/14/13)
- Utilization Review Determination (dated 5/30/13)
- Medical Records were requested but not submitted for this review.
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8 – Neck and Upper Back Complaints, pg. 181
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 9 – Shoulder Complaints, pg. 212
- American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12 – Low Back Complaints, pg. 308
- Official Disability Guidelines (ODG), (updated 2013), web edition, online edition, Chapters – Neck and Upper Back, Shoulder, Low Back – Lumbar & Thoracic, Physical Therapy Section

1) Regarding the request for 12 physical therapy sessions for the cervical spine, lumbar spine and the right shoulder:

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

The Claims Administrator based its decision on the ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8 – Neck and Upper Back, Chapter 9 – Shoulder Complaints, and Chapter 12 – Low Back Complaints, of the Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines (ODG), (updated 2013), Neck and Upper Back, Shoulder, Low Back – Lumbar & Thoracic Chapters, Physical Therapy Section, which is a Medical Treatment Guideline (MTG) not in the MTUS and is the most recent version of the MTG. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

On 1/6/13 employee received injuries to cervical spine and the right hip, shoulder, and chest wall. Six physical therapy visits were requested on 1/24/13. MRI of cervical and lumbar spine confirmed plain film findings of no acute findings, disc "space" narrowing, and some degenerative changes.

ACOEM guidelines recommend 1-2 physical therapeutic visits "for education, counseling, and evaluation of home exercise for range of motion and strengthening". Medical records were not available for review to substantiate the number of completed physical therapy sessions undertaken or to provide evidence of the employee's functional gain from these sessions. Therefore, requested 12 physical therapy sessions for the cervical spine, lumbar spine and the right shoulder **are 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

/lkh

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.