

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/2/2013
Date of Injury:	9/14/2009
IMR Application Received:	8/14/2013
MAXIMUS Case Number:	CM13-0010831

- 1) MAXIMUS Federal Services, Inc. has determined the request for **outpatient functional restoration program evaluation** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/14/2013 disputing the Utilization Review Denial dated 8/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **outpatient functional restoration program evaluation 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 & 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.

Expert Reviewer Case Summary:

The patient sustained a work-related injury on 09/14/2009, and has ongoing neck, back, and right shoulder pain rated at a 6/10 that is exacerbated by movements. Physical findings included restricted lumbar range of motion, weakness of the left wrist and hand with reduced grip strength, and 3/5 weakness of the left lower extremity. It was also noted that the patient had decreased sensation to light touch throughout the deltoid area bilaterally and lateral legs bilaterally. The patient had a positive Spurling's test and a positive slump test. The patient's diagnoses included abnormal gait, frozen shoulder, shoulder impingement, lumbosacral spondylosis without myelopathy, lumbosacral neuritis or radiculitis, sciatica, and myofascial pain/myositis, and the treatment plan included a functional restoration program.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for outpatient functional restoration program evaluation :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section - Chronic pain programs (functional restoration programs), pages 31-33, which is part of the MTUS.

Rationale for the Decision:

The employee does have continued weakness and pain issues. California Medical Treatment Utilization Schedule recommend a thorough evaluation to include baseline functioning testing to report functional improvement while participating in the program. The employee must also not be a candidate for surgery with documentation of motivation to change and all negative predictors of success are identified. The clinical documentation submitted for review does not provide evidence of a Functional Capacity Evaluation to support efficacy of this treatment modality. Additionally, the employee's candidacy for surgical intervention was not addressed in the clinical documentation. Also, the employee's motivation to change and be compliant with participation in a functional restoration program was not documented. Negative predictors were not assessed. **The request for outpatient functional restoration program evaluation 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,

Paul Manchester, MD, MPH
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.