MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/27/2013

IMR Case Number:	CM13-0011516	**Date of Injury:**	11/21/2008
Claims Number:	[redacted]	**UR Denial Date:**	7/16/2013
Priority:	Standard	**Application Received:**	8/14/2013
Employee Name:	[redacted]		
Provider Name:	[redacted]		
Treatment(s) in Dispute Listed on IMR Application:	Remaining week of HELP program		

DEAR [redacted]

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury is 11/21/2008. The patient's diagnoses include low back pain, depression, opioid dependence, lumbar disc degeneration, and chronic pain.

Initial physician review notes the patient was status post laminectomy/fusion at L4-5 in November 2009 and status post left knee arthroscopies three times, most recently in December 2012, and that the patient was not able to return to work since 2009. That review notes an appeal letter from the treating physician of 06/28/2013 noted that the patient had completed the equivalent of 15 full days in a functional restoration program. The reviewer noted that there had been discontinuation of some medications and a reported decrease in others. This did not support the necessity of the intensity of a functional restoration program. That reviewer concluded that there were not gains to support efficacy to warrant continuation in the program.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Request for 1 HELP program, 3 full days is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May 2009), Functional restoration programs, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 32, which is part of the MTUS.

The Physician Reviewer's decision rationale:
The Chronic Pain Medical Treatment Guidelines, section on chronic pain management/functional restoration programs, page 32, states, "Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and

objective gains." The medical records indicate that the progress and goals being made and proposed in this case do not require an intensive functional restoration program but rather could be accomplished through traditional outpatient means. The medical records, appeal letter, and guidelines do not support the necessity of the requested treatment. This treatment is not medically necessary.

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.

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