

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

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/12/2013
Date of Injury:	12/17/2011
IMR Application Received:	8/19/2013
MAXIMUS Case Number:	CM13-0013350

- 1) MAXIMUS Federal Services, Inc. has determined the request for **additional physical therapy two times per week for six weeks for the right knee, right shoulder, lumbar, and cervical spine is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/19/2013 disputing the Utilization Review Denial dated 8/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/30/2013. 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 **additional physical therapy two times per week for six weeks for the right knee, right shoulder, lumbar, and cervical 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 Orthopedic Surgery, and is licensed to practice in Louisiana and Texas. 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 is a 46 year old female who sustained a work related injury on 12/17/2011. The patient was treated with physical therapy, medication management, and cortisone injections. The patient reported minimal relief with the cortisone injections. An Agreed Medical Examination in 10/2012 indicated the patient was not at maximum medical improvement as she was a surgical candidate for the right knee. The patient subsequently underwent an arthroscopic partial meniscectomy on 05/15/2013 followed by extensive physical therapy. Physical therapy note dated 06/13/2013 indicated the patient tolerated all treatment with mild to moderate discomfort but had increased right knee active range of motion of 0 to 132 degrees at the end of treatment. The most recent physician's progress report dated 08/12/2013 indicated the patient had tenderness, weakness, spasms, and limited range of motion. The treatment plan consisted of urine testing for medication compliance, continued medication regimen, and physical therapy for the shoulder/lumbar spine/cervical spine at two times a week over six weeks.

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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for additional physical therapy two times per week for six weeks for the right knee, right shoulder, lumbar, and cervical spine:

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 Knee Complaints Chapter ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) pages 337-339, Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 203 & 204, and ACOEM Guidelines, 2nd Edition, 2004, pages 299 & 300, which are part of the MTUS, and the Official Disability Guidelines, Knee and Leg Chapter, Back Chapter, Shoulder Chapter, and Neck and Upper Back Chapter, which are not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99, and the Post-Surgical Treatment Guidelines, pages 10 & 24, which are part of the MTUS.

Rationale for the Decision:

The MTUS Postsurgical treatment guidelines state, "General course of therapy" means the number of visits and/or time interval which shall be indicated for postsurgical treatment for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section. CA MTUS would support 12 visits over 12 weeks status post meniscectomy. CA MTUS recommends 9-10 sessions of physical therapy for myalgia and myositis to address the employee's right shoulder, lumbar spine and cervical spine. The evaluations submitted for review are not clear as to the progress since therapy was initiated. It is noted that the employee had right knee surgery in 05/2013 followed by extensive physical therapy of the right knee, right shoulder, lumbar and cervical spine. The employee is noted to have received the recommended sessions of physical therapy directed to the right shoulder, low back, cervical spine, and right knee. The request for additional therapy for the right knee exceeds the post-operative time interval CA MTUS recommends. There is no indication why the employee would continue to require formal physical therapy when a self-directed home exercise program has been instructed. Furthermore, there are no initial or interim evaluations submitted for review to determine the employee's progress or compliance with therapy or with the home exercise program. There is no documentation submitted for review indicating exceptional factors to support the necessity of additional physical therapy over the guideline recommendations. **The request for additional physical therapy two times per week for six weeks for the right knee, right shoulder, lumbar, and cervical 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,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/bh

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.