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## Independent Medical Review Final Determination Letter

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[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0016623	<b>Date of Injury:</b>	08/25/2008
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/15/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/26/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED]		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PT 2X3 LUMBAR / NOT MEDICALLY CERTIFIED BY PA			

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]  
[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 patient is 58-year-old injured worker who reported an injury on 08/25/2008. The patient is diagnosed with thoracic or lumbosacral neuritis or radiculitis, lumbosacral spondylosis without myelopathy, pain in joint involving the shoulder, migraines, muscle spasm, sacroiliitis, headache, and cervicgia. The patient was seen on 08/23/2013 for complaints of low back pain, headaches, and upper extremity pain. Physical examination of the lumbar spine revealed normal gait, positive straight leg raising on the left, tenderness to palpation, right paravertebral spasm, 25 degree right and left lateral flexion, 80 degrees flexion, and 25 degree extension. The patient demonstrated 5/5 motor strength of bilateral lower extremities with 2+ reflexes. Treatment recommendations included continuation of current medications and a selective nerve root block versus lumbar epidural steroid injection.

### IMR DECISION(S) AND RATIONALE(S)

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

**1 Physical therapy for low back/lumbar, two times a week for three weeks is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 98-99, which is part of the MTUS.

The Physician Reviewer's decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state, active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process. Guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. Treatment for radiculitis includes 8 to 10 visits over 4 weeks. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. The medical records provided for review indicates that the employee has completed 12 sessions of physical therapy to date. The latest physical therapy note dated 08/01/2013 indicated continued complaints of low back pain. A progress note dated 08/07/2013 reported decreased range of motion and continued complaints of low back pain. Without documentation of functional improvement or exceptional factors, continuation of treatment cannot be determined as medically appropriate. There is no indication as to why the employee would not benefit from a self-directed home exercise program. **The request for physical therapy for low back/lumbar, two times a week for three weeks is not medically necessary and appropriate.**

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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.

[REDACTED]

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