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

Notice of Independent Medical Review Determination

Dated: **12/6/2013**

Employee:	
Claim Number:	
Date of UR Decision:	8/5/2013
Date of Injury:	3/30/2013
IMR Application Received:	8/26/2013
MAXIMUS Case Number:	CM13-0017209

1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy two (2) times a week for four (4) weeks for the lumbar spine is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/5/2013. 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 **physical therapy two (2) times a week for four (4) weeks for the lumbar spine** is **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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 33 year old female who sustained an industrial injury on March 30, 2013. She is now greater than 4 months post injury. The patient was injured after lifting a case of soda. MRI of the lumbar spine dated July OS, 20 13 reveals, "(1) L4-S: Mild to moderate disc degeneration with diffuse disc bulge and a central to right foraminal disc protrusion. There is a small midline posterior annular fissure. Mild degenerative facetarthritis. (2) LS-S 1: Moderately severe disc degeneration with broad-based posterior disc bulge in which there is a small central extruded posterior disc fragment in which there is a small annular fissure. There is also mild bulging into the neural foramina with mild to moderate degenerative facet arthri tis and borderline left foraminal stenosis."Report dated July 08,2013 indicates that the patient has had no-response to RF ablation performed 2 weeks ago. The patient is attending PT,but feels worse. There is pain, weakness, and stiffness. EMG is pending. On exam, there is TTP and moderate spasm, SLR to 7S degrees., and 4/S strength in the BLEs. Plan is to obtain an MRI. The patient was to continue PT and is prescribed topical ointments and a TENS unit. It is noted that the topical medications are prescribed due to GI distress. Overall, the patient feels worse. A TENS unit helps with pain. Pain is 4/10 with cream and 8/10 without. The cream also helps the patient to do ADLs, exercise, and work. Electrodiagnostic testing dated July 09,2013 was found to be a normal study without evidence of lumbar radiculopathy or peripheral neuropathy.Peer review dated July 23, 2013 recommended to non-certify the request for PT x 8. The patient has had physical therapy without any report of a response. The total number of sessions is not clarified. There was also no clarification of improvement. A second peer review 8/5/2013 again denied the request for PT x 8 stating that there is no ongoing progress is noted and she appears to have reached a plateau.Also that there was no clarification of how much PT the patient has had. The request presented again is whether PT 2x 4 weeks lumbar spine is necessary. From PT notes submitted this time it appears that patient has had approximately 6 visits of PT as well as a PT evalution on 7/12/13. There are limited objective findings in the

notes except for range of motion noted on 5/10/13 and on the evaluation dated 7/12/13. There are subjective reports of a decreased with pain on these visits. On a physician note dated 7/29/13 there is documentation that the patient feels less pain in PT. The same document indicates under objective findings and subjective complaints that patient feels worse. EMG on 7/9/13 by [redacted] was normal. A Physical Exam by [redacted] 7/9/13 indicates no atrophy, normal muscle strength testing, normal reflexes, no clonus, full range of motion in the lower extremities and no paraspinal tenderness. There is decreased sensation in the bilateral L5 distribution.

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 physical therapy two (2) times a week for four (4) weeks for the lumbar 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 Chronic Pain Medical Treatment Guidelines, Physical Medicine, which is part of the MTUS, and the Official Disability Guidelines, Lumbar Chapter, which is not part of the MTUS.

   The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Low Back Complaints, pg. 48, 293, and the Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, pg. 99, which are part of the MTUS.

   Rationale for the Decision:
   MTUS guidelines state to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The guidelines do allow up to 10 visits for the employee's condition. There are no significant documentation of strength deficits or other documentation submitted that would justifiy continued PT. A 7/9/13 physician note indicates for the BLE there was no atrophy, normal muscle strength testing, normal reflexes, no clonus, full range of motion in the lower extremities and no paraspinal tenderness. There is decreased sensation in the bilateral L5 distribution . Per documentation the employee has had at least 6 visits of PT with no clear treatment goals. Per ACOEM guidelines : With a prescription that clearly states treatment goals, a physician can use communication with the therapist to monitor such variables as motivation and compliance. Documentation submitted indicates no significant objective findings or significant functional improvement that demonstrate response to treatment so far. Range of motion is not sufficient for objective improvement in the employee's condition. Per the ACOEM (low back

chapter) : “because of the marked variation among persons with symptoms and those without, range-of-motion measurements of the low back are of limited value.” On a documented submitted 7/29/13 there is documentation under objective findings and subjective complaints that the employee feels worse. The employee should be able to perform a home exercise program at this point. **The request for physical therapy two (2) times a week for four (4) weeks for the lumbar 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

/bc

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.