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**Notice of Independent Medical Review Determination**

Dated: 10/2/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	7/13/2001
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0002018

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 2 times a week for 6 weeks for the lumbar spine **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 2 times a week for 6 weeks for the lumbar 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 Occupational Medicine, 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.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 9, 2013:

“According to the clinical documentation dated 6/18/13 by [REDACTED], MD, the patient complained of chronic low back condition. The patient described the pain as intermittent to frequent bilateral sided low back pain that was greatest at the end of the day. There was also a sensation of heaviness involving the buttock and posterior thighs, bilaterally, in relation to change in position, and stairs. The patient found it necessary to lie down later in the day to rest. On examination, the patient had mild tenderness noted on palpation of the posterior lumbar midline and right sacroiliac joint.

The range of motion of the back was limited, such as the patient flexed forward with the fingertips one and a half feet from the floor. The patient extended 5 degrees, and laterally bended 20 degrees to the right and 25 degrees to the left. Low back pain was reproduced at the extremes of extension and lateral bending to the right. The straight leg raisers were negative bilaterally. The patient's diagnoses were improved progressively worsening chronic low back pain (greater to the right) with bilateral lower extremity radiculitis, status post lumbar decompression L3-L4 through L5-S1, with fusion at L4-L5 and L5-S1 with transforaminal lumbar interbody fusion (TLIF) and posterolaterally extending from L3 to S1 with instrumentation (9/27/12) for lumbosacral spinal disk degenerative disease (ODD) (spinal stenosis and instability), status post lumbosacral spine musculoligamentous strain/contusion (7/14/01). superimposed on lumbosacral spinal ODD. This is a review for medical necessity of physical therapy 2 times a week for 6 weeks for lumbar”.

### **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 for Independent Medical Review (received 07/18/2013)
- Utilization review Determination from [REDACTED] (07/09/2013)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for physical therapy 2 times a week for 6 weeks for the lumbar spine:**

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 98-99, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Low Back Chapter, Physical Medicine section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

#### Rationale for the Decision:

The employee was injured on 7/13/2001 and has experienced intermittent to frequent lower back pain radiating to the bilateral thighs. A progress report dated 7/15/2013 noted the employee is cannot stand, walk, sit, or drive. The employee has comorbid pulmonary embolus and is on Coumadin. X-rays demonstrate a solid interbody fusion at L4-L5 and L5-S1. Treatment has included analgesic medications, physical therapy, and long and short acting opioids. A progress note dated 6/18/2013 indicates the employee would like to wean off of opioids. A request was submitted for physical therapy 2 times a week for 6 weeks for the lumbar spine.

The MTUS Chronic Pain Guidelines indicate that demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. Further, MTUS section 1920.20 states that functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation. Medical records submitted for review indicate the employee has had prior unspecified amounts of physical therapy, including at least 11 sessions in 2013, which are in excess of the 9 to 10 session course recommended in the MTUS Chronic Pain Guidelines for myalgias and/or myositis of various body parts. There is no clear evidence of functional improvement following completion of previous physical therapy treatment. The employee remains highly dependent on medical treatment including analgesic medications. Therefore, the request for physical therapy 2 times a week for 6 weeks for the lumbar spine **is not medically necessary or 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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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.