

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	9/13/2007
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0003789

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 2 times a week for 3 weeks on the right shoulder and back **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. 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 3 weeks on the right shoulder and back **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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular 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.

Expert Reviewer Case Summary:

Per 3/11/11 QME (Qualified Medical Examination) documentation patient suffered an industrial injury to the upper and lower back on September 13, 2007. The patient continued to work without restrictions with this facility until September 2009. On 3/11/11 QME evaluation patient admits being noncompliant with her self-directed back exercise program. The patient reports her low back condition does not interfere with activities of daily living or occupation. The patient's diagnosis on the 3/11/11 QME was: 1. Cervical spine strain 2. Mild impingement syndrome, right shoulder 3. Electrodiagnostic evidence for carpal tunnel syndrome 4. Low back strain. Treatment recommendations on this date were: No more medical evaluation and treatment is indicated for residual symptoms related to the September 13, 2007 industrial injury. This includes recently recommended diagnostic studies that in the past are reported as being unremarkable for pathology attributed to the industrial injury.

The carpal tunnel diagnosis is made solely on electrodiagnostic results without corroborative physical findings and is considered an incidental finding unrelated to this injury. Any more evaluation or treatment for bilateral carpal tunnel syndrome is done on a non-industrial basis. The patient's neck/upper back symptoms are caused by mild impingement syndrome of the right shoulder caused by the incident. The patient's upper back, neck and shoulder symptoms will resolve by her doing her stretching exercises. The patient's low back symptoms will resolve with stretching exercises. No more evaluation and treatment is indicated on an industrial basis. Per 1/9/2012 QME evaluation: Extensive medical evaluation and treatment including multiple specialty consultations (3/10/08, 5/04/10, 8/18/10 and 10/04/10) found no substantial medical evidence for neurological or orthopedic pathology caused by the industrial injury to account for the applicant's subjective complaints.

There was no substantial medical evidence from the reevaluation of the patient and review of the updated medical records supporting the medical need for more medical evaluation and treatment for symptoms attributed to the September 2007 industrial injury. 12/30/08: treatment recommendations included acupuncture and physical therapy as well as continuing with medication. The patient remained on temporary partial disability. 3/3/11 QME indicates: The patient reports treatment included several courses of physical therapy and medication with temporary pain relief experienced. Additionally, 1/9/13 QME indicates: Diagnosed with soft tissue strains she was allowed to return to modified work activities while receiving treatment that included medication and physical therapy from Dr. [REDACTED]. UR review dated 7/13/13 denied PT 2 x week for 2 weeks. 7/8/13 Documentation by Dr. [REDACTED] indicates under subjective complaints: "Painful upper back, lower back, neck, shoulders with occasional numbness of hands are slightly better." This request is again whether PT 2 x 2 weeks for right shoulder back is medically necessary.

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

1) Regarding the request for physical therapy 2 times a week for 3 weeks on the right shoulder and back:

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, pages 98 – 99, which is part of the MTUS, and the ODG Physical Therapy Guidelines, which are not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), pages 98 – 99, which is part of the MTUS, as well as the Official Disability Guidelines, Low Back chapter, Physical Therapy Guidelines, which is not part of the MTUS.

Rationale for the Decision:

According to the Chronic Pain Medical Treatment Guidelines, there should be a fading of frequency with active self directed home program. Per records it is unclear how many actual physical therapy (PT) visits the employee has had in the past with no clear documentation of functional improvement or permanent return to work made from prior PT. At this point, the employee should be well versed in a home exercise program. Additionally, per documentation patient had a Panel QME on 3/3/11, no further medical care was recommended for the neck and back. Documentation indicates that the employee's upper back, neck and shoulder symptoms will resolve by her doing her stretching exercises. The employee's low back symptoms will resolve with stretching exercises. No more

evaluation and treatment is indicated on an industrial basis. Additionally, the records show that, during this evaluation, the employee admitted to non-compliance with the home exercise program and that the low back pain does not interfere with activities of daily living. An additional QME 1/9/12 indicates shows no significant changes since March 2011 to account for the employee's subjective complaints caused by the September 2007 injury and no medical need based on medical records for more medical evaluation and treatment for symptoms attributed to the September, 2007 industrial injury. **The request for physical therapy 2 times a week for 3 weeks on the right shoulder and back 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,

Paul Manchester, MD, MPH
Medical Director

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

/dat

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.