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## Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0005312	<b>Date of Injury:</b>	10/05/2012
<b>Claims Number:</b>	██████████	<b>UR Denial Date:</b>	07/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2013
<b>Employee Name:</b>	██		
<b>Provider Name:</b>	██████████ MD		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>	Physical therapy two to three times a week for four weeks		

DEAR ██████████

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: OVERTURN. This means we decided that all 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, ██████████

## 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, has a subspecialty in 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 underlying date of injury in this case is 12/5/2012. The treating diagnosis is lumbago. This patient is a 48-year-old woman who has reported pain in the neck and the thoracic spine, and low back. The treating diagnosis include lumbar sprain, lumbar degenerative disc disease, cervical sprain with whiplash, and thoracic sprain.

An initial physician review noted that the patient had completed 6 physical therapy visits and that there was limited information documenting the patient's response to therapy so far and that there were no therapy notes submitted for review documenting specific progress. Therefore, the initial reviewer recommended noncertification.

A physician progress note on May 29, 2013 indicated that the patient reported that she attended physical therapy and was told by her therapist that her pain needed to be better controlled in order to progress in therapy and that the patient had seen a chiropractor for 9 visits but did not benefit. That physician requested authorization for physical therapy for lumbar mobilization, stabilization, pain control, myofascial release, pain control with physical modalities, and review of a home exercise program.

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

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

**1. Physical therapy 2-3 times a week for 4 weeks is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS and ODG-TWC, which is not part of the MTUS.

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

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic Pain Medical Treatment Guidelines, section on Physical Medicine, pages 98-99 recommends "Active therapy requires an internal effort by the individual to complete a specific exercise or task . . . Allow for fading of treatment frequency plus active self-directed home physical medicine." The available medical records do contain a discussion in past physical therapy and indication that the patient did not progress in that therapy or chiropractic. In turn, the treating physician has written a specific physical therapy prescription identifying specific goals and methods for an alternate prescription for physical therapy. This treatment plan is consistent with the guidelines for physician supervision of physical therapy. This request is medically necessary.

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]

CM13-0005312