

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/24/2013
Date of Injury: 6/23/2008
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008707

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]

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 & Rehabilitation, has a subspecialty in Interventional Spine 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 a 59 Y, F with a date of injury of 2/28/2012. The patient's diagnoses include: lumbar spine disc protrusions, lumbar radiculopathy, cervical spine sprain/strain, right shoulder sprain/strain, left upper extremity radiculopathy, right knee internal derangement, myospasms, and cervical spine multilevel disc bulges. The utilization review letter dated 7/7/13 by [REDACTED] noted that the progress report dated 11/14/12 by Dr. [REDACTED] indicated that the patient had worsening low back pain with worsening radiation. Objective findings included tenderness to palpation with spasms of the paraspinals with limited range of motion of the lumbar spine secondary to pain. Treatment to date consisted of, but not limited to chiropractic, acupuncture, medication and home exercises. A retrospective request for 12 PT visits between 10/3/12 and 11/15/12 was denied due to lack of information. The progress report dated 10/3/12 by Dr. [REDACTED] noted that the patient complained of worsening LBP with worsening radiation, numbness, tingling, and cramping going down her legs. The patient stated that the therapy and acupuncture helped decrease her pain temporarily. The patient had limited ROM of the lumbar spine secondary to pain. Continuation of physiotherapy at 2 times a week for the next 6 weeks was recommended.

IMR DECISION(S) AND RATIONALE(S)

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

1. Physical Therapy 2x per week for 6 weeks for the lumbar is not medically necessary and appropriate.

The Claims Administrator based its decision on the Post-Surgical Medical Treatment Guidelines, page 24, which is part of the MTUS.

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

The Physician Reviewer's decision rationale:

The IMR application form notes the date of UR decision as 7/1/13. The UR letter with that date did not include a physical therapy request. The correct UR letter was dated 7/7/13 and was on page 293 out of 569. The utilization review letter dated 7/7/13 by [REDACTED] noted that the progress report dated 11/14/12 by Dr. [REDACTED] indicated that the employee had worsening low back pain with worsening radiation. Objective findings included tenderness to palpation with spasms of the paraspinals with limited range of motion of the lumbar spine secondary to pain. Treatment to date consisted of, but not limited to chiropractic, acupuncture, medication and home exercises. A retrospective request for 12 PT visits between 10/3/12 and 11/15/12 was denied due to lack of information. The progress report dated 10/3/12 by Dr. [REDACTED] noted that the employee complained of worsening LBP with worsening radiation, numbness, tingling, and cramping going down the legs. The employee stated that the therapy and acupuncture helped decrease the pain temporarily. The employee had limited ROM of the lumbar spine secondary to pain. Continuation of physiotherapy at 2 times a week for the next 6 weeks was recommended. MTUS pages 98, 99 regarding physical medicine allow for fading of treatment frequency plus active self-directed home physical medicine. 8-10 visits over 4 weeks are supported for neuralgia, neuritis and radiculitis. The requested 12 visits of PT is not supported by the guidelines noted above, therefore recommendation is for denial. **The request for physical therapy 2x per week for 6 weeks for the lumbar is not medically necessary and appropriate.**

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]

[REDACTED]

[REDACTED]