

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: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/29/2013
Date of Injury: 2/1/2013
IMR Application Received: 8/9/2013
MAXIMUS Case Number: CM13-0009372

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 and Rehabilitation and Pain Medicine and is licensed to practice in Ohio and Texas. 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 51-year-old male who reported an injury on 02/01/2013. The patient is currently diagnosed with a right knee sprain, right hip sprain, and right knee contusion. The patient was most recently evaluated by Dr. [REDACTED] on 08/12/2013. The patient was an [REDACTED] [REDACTED] and was assisting in the kitchen when he fell, injuring his right knee and leg. He presently complains of 7-8/10 right hip and knee pain. Objective findings included tenderness to palpation along the right hip and lateral right knee joints, positive piriformis, quadriceps, and hamstring muscle with hypertonicity, normal range of motion of the right hip, slightly decreased flexion of the right knee, normal deep tendon reflexes, and positive piriformis muscle and FABER testing. It was recommended the patient receive treatment at a rate of 1 time per week for 4 weeks. Home exercise was also recommended for strengthening.

IMR DECISION(S) AND RATIONALE(S)

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

1. Four (4) sessions of chiropractic manipulation is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS 2009, Chronic Pain Treatment Guidelines 7/18/2009, Pgs. 58-60 and Page 1, Consultation, American College of Occupational and Environmental Medicine (ACOEM), Guidelines, Second Edition, Chapter 7, Page 127, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Page 58, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Treatment for the knee is not recommended. As per the physical examination on 08/12/2013, there was only tenderness to palpation, positive FABER and piriformis testing, normal range of motion of the hip, and slightly decreased flexion of the right knee. It was noted on a previous utilization review report dated 07/29/2013 by Dr. [REDACTED] the treating provider confirmed twenty-four (24) visits had been completed to date. The employee's right hip and knee pain remained relatively unchanged with conservative treatment. The latest clinical documentation submitted for review fails to provide evidence of a recent loss of functional capacity, a statement as to what prior functional loss was restored by prior treatment, or a statement as to what functional capacity can be reasonably expected by the requested treatment. As guidelines do not recommend manual therapy and manipulation for the knee, the request cannot be determined as medically appropriate. **The request for four (4) sessions of chiropractic manipulation is not medically necessary and appropriate.**

2. Four (4) sessions of physical therapy is not medically necessary and appropriate.

The Claims Administrator based its decision on the CA MTUS 2009, Chronic Pain Treatment Guidelines 7/18/2009, Pgs. 58-60 and Page 1, Consultation, American College of Occupational and Environmental Medicine (ACOEM), Guidelines, Second Edition, Chapter 7, Page 127, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pages 98-99, which is part of the MTUS and the Official Disability Guidelines (ODG), Knee Chapter, Hip & Pelvis Chapter, Online Edition, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. Official Disability Guidelines list medical treatment for a sprain of the knee and leg to include twelve (12) visits over eight (8) weeks. Medical treatment for a sprain or strain of the hip and thigh include nine (9) visits over eight (8) weeks. As per the clinical notes submitted, the employee's most recent physical examination only revealed tenderness to palpation, positive FABER and piriformis testing, normal range of motion of the hip, and only slightly decreased flexion of the right knee. Again, the previous utilization review report dated 07/29/2013 indicated twenty-four (24) sessions had been completed for the right hip and knee with unchanged symptoms. The employee does not demonstrate significant musculoskeletal or neurological deficits that would warrant the need for skilled physical medicine treatment at this time. There was no indication as to why this employee could not participate in a further self-directed home exercise program. Based on the clinical information received, the request is non-certified. **The request for four (4) sessions of physical therapy 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.



CM13-0009372