

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/4/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	1/27/2005
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0010335

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/18/2013. 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 two times a week for six weeks** 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, 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:**

This patient was injured on 01/27/2005. Diagnoses included cervical radiculopathy, degenerative disc disease of the cervical spine, and cervical disc bulges at C4-5, C5-6, and C6-7. The patient is status post a multilevel anterior cervical discectomy and fusion on 07/09/2012. On initial review, the reviewer noted that the primary physician's progress report of 06/13/2013 stated that the claimant's fusion was stable and that the patient had limited range of motion with tenderness in the related paravertebral muscles and pain with cervical extension. The provider had recommended physical therapy to the cervical spine. The prior reviewer noted that there was no evidence of objective or functional improvement from prior completed physical therapy sessions.

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

**1) Regarding the request for physical therapy two times a week for six weeks:**

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, which is part of the MTUS, as well as the Official Disability Guidelines, Neck and Upper Back Procedure Summary, which is not part of the MTUS.

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

Rationale for the Decision:

A review of the records indicates that the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines anticipates that this employee would have transitioned to an independent active home rehabilitation program after prior postoperative physical therapy. The current treating physician notes do not discuss a rationale as to why additional PT is supervised rather than an independent home rehabilitation program that would be indicated currently. These records do not discuss the functional progress from past therapy or specific functional goals and methods for the currently proposed additional physical therapy. **Therefore, the request for physical therapy two times a week for six weeks 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.