

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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



**Notice of Independent Medical Review Determination**

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/5/2013
Date of Injury:	4/7/2013
IMR Application Received:	8/20/2013
MAXIMUS Case Number:	CM13-0013680

- 1) MAXIMUS Federal Services, Inc. has determined the request for **functional restoration program (no specific F & D) is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/20/2013 disputing the Utilization Review Denial dated 8/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/1/2013. 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 **functional restoration program (no specific F & D) is medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Records who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Georgia & 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 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:**

The patient is a 32-year-old male who reported an injury on 04/07/2011. The patient was reportedly carrying a large piece of wood weighing approximately 50 to 60 pounds on his right shoulder and slipped while walking on a rock pathway. Current diagnoses include lumbago, right leg sciatica, chronic low back pain, reactive myofascial pain bilateral, lumbar degenerative disc disease, deconditioning, severe depression, sleep disorder, and pain disorder associated with both psychological factors and a general medicine condition. Previous treatments to date include medication, modified duties, work hardening evaluation, TENS therapy, physical therapy, massage therapy, and an exercise program. Current medications include tramadol, GABAdone, and diclofenac sodium. A multidisciplinary evaluation was conducted on 08/30/2013 by [REDACTED]. The patient received a score of 54% on the Oswestry Disability Questionnaire, indicating severe disability. He also demonstrated a significant loss of functional independence resulting from his chronic pain upon physical therapy evaluation. It was determined that he was an appropriate candidate for an interdisciplinary pain management program.

### 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
  - Employee/Employee Representative
  - Provider

### 1) Regarding the request for functional restoration program (no specific F & D):

#### 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 30-32, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Pages 30-34, which is part of the MTUS.

#### Rationale for the Decision:

MTUS Chronic Pain Guidelines indicate that chronic pain programs are recommended where there is access to programs with proven successful outcomes, for employees with conditions that put them at risk of delayed recovery. Employees should be motivated to improve and return to work, and meet the employee's selection criteria. Criteria includes an adequate and thorough evaluation, including baseline functional testing, previous methods of treating chronic pain that have been unsuccessful, and an absence of other options that are likely to result in significant clinical improvement, a significant loss of ability to function independently resulting from chronic pain, employees who are not candidates where surgery or other treatments would be clearly warranted, employees who exhibit motivation to change and are willing to forego secondary gains, and negative predictors of success should be addressed. Total treatment duration should generally not exceed 20 full day sessions. According to the medical records submitted, a previous Utilization Review Report was submitted on 07/22/2013. Non-certification of the functional restoration program request was issued at that time. Additional information was required to certify the request. The employee has since been evaluated by behavioral medicine, physical therapy, and pain medicine. There is now documentation of a significant loss of ability to function independently, exhaustion of previous conservative treatments, and the employee's motivation and willingness to change. **The request for functional restoration program (no specific F & D) is medically necessary and 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.