

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

1178

[REDACTED]
 [REDACTED]
 [REDACTED]
 [REDACTED]

Dated: 12/30/2013

| | | | |
|---|---------------|------------------------------|------------|
| IMR Case Number: | CM13-0018674 | Date of Injury: | 01/28/2008 |
| Claims Number: | [REDACTED] | UR Denial Date: | 08/21/2013 |
| Priority: | STANDARD | Application Received: | 08/30/2013 |
| Employee Name: | [REDACTED] | | |
| Provider Name: | [REDACTED] MD | | |
| Treatment(s) in Dispute Listed on IMR Application: | | | |
| PHYSICAL THERAPY 2XWK X 4WKS; CERVICAL AND LUMBAR SPINE | | | |

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 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 01/28/2008. The primary treating diagnosis is cervical brachial syndrome. The patient is status post an L4 through L5 discectomy of 06/2012. Subsequently, the patient has reported continued low back pain, as well as bilateral wrist pain. The patient is additionally status post carpal tunnel surgeries in 2008. The patient has been noted to have restricted lumbar range of motion, as well as left Extensor hallucis longus muscle (EHL) weakness at 4/5. An initial physician report notes that the number of physical therapy visits previously performed is unknown and that a Physical Therapy evaluation recommended physical therapy primarily to the lumbar spine rather than cervical spine. That physician review indicates, as well, that the treating provider indicated that request for physical therapy to the cervical spine was not requested and that the number of prior physical therapy visits is unknown.

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 times a week for 4 weeks cervical and lumbar spine is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Practice Guidelines Neck and Upper Back Complaints chapter, which is part of the MTUS, and the Official Disability Guidelines section on Physical Therapy Neck and Upper Back chapter, which is not part of the MTUS.

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

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines section on physical medicine recommends a "fading of treatment frequency plus active self-directed home physical medicine." The medical records provided for review at this time do not clearly indicate a rationale as to why this employee would require additional supervision rather than independent physical therapy or what the goals would be of the proposed additional supervised therapy. **The request for Physical therapy 2 times a week for 4 weeks cervical and lumbar spine is not medically necessary and appropriate.**

/MCC

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]

CM13-0018674