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**Notice of Independent Medical Review Determination**

Dated: 10/24/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/3/2013
Date of Injury:	7/20/2010
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003715

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy two (2) times a week for three (3) weeks **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/2/2013. 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 (2) times a week for three (3) 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.

### Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 3, 2013:

The request for treatment indicates the diagnoses of degenerative disc disease, cervical facet syndrome and chronic pain syndrome. The progress note indicates complaints of low back pain and stiffness. There was a history of a thoracic epidural steroid injection, completed approximately a year ago, with 90% relief of pain. A recurrence of the thoracic pain was noted as of February 2013. The claimant continues to treat with aquatic therapy two times a week. The physical examination noted a limitation of range of motion, spasm and tenderness of the paravertebral musculature of the lumbar spine. The injured worker is said to be 61 inches, 254 pounds and normotensive (126/80). Given that the request is for a thoracic epidural steroid injection, and there are no enhanced imaging studies or other diagnostic assessment identifying a verifiable radiculopathy, tempered by the treatment plan parameters outlined in the applicable guidelines, this no clear clinical indication at this time to support an additional epidural steroid injection. Based on this lack of information this request is not certified. Relative to the physical therapy, it is noted that the injured employee continues with aquatic protocol. Therefore, given the relative efficacy of this self-motivated aquatic therapy protocol I do not see any clinical information presented to support the request for physical therapy. Accordingly, this request is not certified. Lastly, there is a request for gabapentin and there is no objectification of appropriate pathology to support this request. There is no objectification of a neuropathic pain generator. Therefore, based on this lack of information this request is also not certified.

### 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 for Independent Medical Review (dated 8/22/13)

- Utilization Review Determination from [REDACTED] (dated 7/3/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for physical therapy two (2) times a week for three (3) weeks:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), page 299, which is part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 98-99, which are part of the MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 7/20/2010 and has experienced low back pain and stiffness. The medical records provided for review indicate diagnoses of degenerative disc disease, cervical facet syndrome, and chronic pain syndrome. Treatments have included physical therapy and aqua therapy. The request is for physical therapy two (2) times a week for three (3) weeks.

The MTUS Chronic Pain Guidelines recommend 8-10 visits of physical medicine. The medical records provided for review indicate that the employee has already received 6 sessions of physical therapy in addition to aquatic therapy during the preceding month of the request with no functional improvement and no changes in pain level. The employee has had adequate therapy and should transition into a home exercise program as recommended by the guidelines. The request for physical therapy two (2) times a week for three (3) weeks **is not 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;

Richard C. Weiss, MD, MPH, MMM, PMP  
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.