

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/24/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/24/2013
Date of Injury: 11/28/2010
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0006519

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, has a subspecialty in Pain Medicine, and is licensed to practice in Oklahoma 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]
- [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 41-year-old male who reported an injury on 11/28/2010. Current diagnoses include pain in a joint of the shoulder, pain in a joint of the forearm, degenerative lumbosacral intervertebral disc, Achilles bursitis or tendinitis, acromioclavicular sprain and strain, wrist sprain and strain, and ankle sprain and strain. The most recent physical examination was documented on 06/13/2013. Documentation revealed slightly decreased abduction and external rotation of the left shoulder, no tenderness, negative Neer and Hawkins testing, normal gait, slightly decreased rotation and lateral flexion, positive straight leg raising on the left, decreased sensation over the left lower extremity, positive Tinel's of the left wrist, normal range of motion of bilateral wrists, tenderness over the lateral malleolus on the left ankle with normal range of motion of bilateral ankles. X-rays obtained of the left wrist, left shoulder, left ankle, and lumbosacral spine indicated normal findings with the exception of slight narrowing at L4-5. Treatment plan included physical therapy treatment 3 times per week for 6 weeks for the lower back and left shoulder, a gym membership with a jacuzzi, a prescription for hydrocodone, and a referral to pain management.

IMR DECISION(S) AND RATIONALE(S)

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

1. Physical Therapy 3 x 6 low back is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 98-99, which is part of MTUS; and the Official Disability Guidelines (ODG), Low Back Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that 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. Treatment for myalgia and myositis, unspecified, includes 9 to 10 visits over 8 weeks with treatment for neuritis and radiculitis including 8 to 10 visits over 4 weeks. According to the latest physical examination of the lumbar spine on 06/13/2013, found in the medical records provided for review, the employee demonstrated 80% normal range of motion with tenderness to palpation and normal gait. The employee does not demonstrate significant musculoskeletal or neurological deficits that would warrant the need for skilled physical medicine treatment at this time. The employee is 3 years status post injury, and there is no indication that the employee has suffered a recent exacerbation with an associated decline in function. There is also no indication as to why this employee would not benefit from a further self-directed home exercise program. Furthermore, the request for physical therapy 3 times per week for 6 weeks exceeds the guideline recommendations for a total duration of treatment. **The request for physical therapy 3 x 6 low back is not medically necessary and appropriate.**

2. Pain management is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 7, pg. 127, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pg. 303, which is part of MTUS; and, the Official Disability Guidelines (ODG), Chronic Pain Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Practice Guidelines indicate physician followup can occur when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected. Individuals with potentially work related low back complaints should have followup every 3 to 5 days by a mid level practitioner or physical therapist

who can counsel the individual about avoiding static positions, medication use, activity modification, and other concerns. The Official Disability Guidelines indicate the determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the healthcare system through self care as soon as clinically feasible. According to the clinical notes submitted, the employee is now 3 years status post injury. Although it was stated on 06/13/2013, that the employee required pain management, the information submitted does not clearly reflect a plan of care for this request. Without documentation or evidence of extenuating circumstances, the medical necessity for this request has not been established. **The request for pain management is not medically necessary and appropriate.**

3. Gym membership with jacuzzi is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Shoulder and Low Back Procedure Summaries, which is not part of MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Chronic Pain Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines indicate that gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Gym memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatment, therefore, not covered under these guidelines. According to the clinical notes submitted for review, the employee was previously authorized a gym membership; however, documentation of specific and sustained benefit was not provided. The medical necessity has not been established. **The request for gym membership with Jacuzzi is not medically necessary and appropriate.**

4. Physical Therapy 3 x 6 left shoulder is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 98-99, which is part of MTUS; and, also used the Official Disability Guidelines (ODG), Shoulder Chapter, Online Edition, which is not part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain guidelines indicate that 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. Individuals are instructed and expected to continue active therapy at home as an extension of the treatment process. The Official Disability Guidelines indicate medical treatment for a sprained shoulder includes 10 visits over 8 weeks. According to the physical examination on 06/13/2013, the employee demonstrated very minimal decreased range of motion with abduction and external rotation, no tenderness or weakness, intact sensation, and negative testing. Documentation of a significant musculoskeletal or neurological deficit with associated functional limitations was not provided. The employee has undergone left shoulder diagnostic arthroscopy on 09/19/2011, and has completed previous postoperative physical therapy. There is limited evidence of exceptional factors that would warrant the continuation of therapy at this time. Furthermore, the request for physical therapy 3 times per week for 6 weeks of the left shoulder exceeds guideline recommendations for a total duration of treatment. At this stage, there is no indication as to why this employee would not benefit from an independent home exercise program. **The request for physical therapy 3 x 6 left shoulder is not medically necessary and appropriate.**

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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.

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