

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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MAXIMUS  
Federal Services



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**Notice of Independent Medical Review Determination**

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	5/6/2010
IMR Application Received:	8/8/2013
MAXIMUS Case Number:	CM13-0008667

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy to Lumbar Spine 3 times 6 is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/8/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/16/2013. 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 to Lumbar Spine 3 times 6 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 & 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:**

The underlying date of injury in this case is 05/06/2010. This patient is a 55-year-old man with a mechanism of injury being that he slipped and fell while carrying drywall. His diagnosis is residual back pain status post a lumbosacral fusion.

The patient was seen in followup by his treating physician on 10/28/2012, at which time additional physical therapy was recommended for pain modulation, to improve range of motion, and to improve lumbosacral stability, noted to improve function and allow the patient to return to work safely. On initial peer review this treatment was found to be not medically necessary.

### **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 physical therapy to Lumbar Spine 3 times 6:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision

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

Rationale for the Decision:

CA MTUS guidelines recommend, “*Allow for fading of treatment frequency plus active self-directed home Physical Medicine.*” The medical records provided for review are not clear in terms of how the proposed physical therapy in the current timeframe would meaningfully differ from past treatment or how these goals would differ from goals from a past home exercise program. It may be appropriate in a chronic case to occasionally request three (3) visits of physical therapy in order to review and modify a home exercise program. However, a request for extensive physical therapy such as the current request for physical therapy three times a week x 6 weeks would not be supported unless there was a fundamental change in the employee’s condition, with specific guidance from the treating physician as to new goals or techniques which differ from past physical therapy. **The request for physical therapy to Lumbar Spine 3 times 6 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,

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.