

Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/17/2013
Date of Injury: 3/11/2005
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008720

- 1) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 2 times per week for 6 weeks for the lumbar spine is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **refill prescription for anti-inflammatories (unspecified) 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 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 2 times per week for 6 weeks for the lumbar spine is not medically necessary and appropriate.**
- 1) MAXIMUS Federal Services, Inc. has determined the request for **refill prescription for anti-inflammatories (unspecified) 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 Preventative Medicine and Occupational Medicine, 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:

All medical, insurance, and administrative records provided were reviewed.

The patient is a represented former [REDACTED] police officer who has filed a claim for chronic low back and shoulder pain reportedly associated with industrial injury of March 11, 2005.

Thus far, the patient has been treated with the following: Analgesic medications; right shoulder total shoulder arthroplasty; transfer of care to and from various providers in various specialties; unspecified amounts of postoperative physical therapies; and extensive periods of time off of work, on total temporary disability. In a utilization report of July 17, 2013, the claims administrator partially approved a six-session trial of supervised physical therapy for the right shoulder and denied a prescription for unspecified anti-inflammatory medications.

The patient's attorney later appealed, on August 1, 2013. An earlier clinical progress note of June 24, 2013 is notable for comments that the patient remains off of work, on total temporary disability. The patient's last shoulder surgery was on June 7, 2012. He exhibits diminished shoulder range of motion with flexion and abduction to 100 to 120 degrees. Total shoulder arthroplasty is in place. The patient is asked to pursue additional physical therapy and remain off of work, on total temporary disability.

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 Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for physical therapy 2 times per week for 6 weeks for the lumbar spine:

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 Official Disability Guidelines, (ODG), Physical Therapy Guidelines, pg. 23, which is not a part of the MTUS.

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

Rationale for the Decision:

According to the Chronic Pain Medical Treatment Guidelines, the recommended treatment course for Myalgia and Myositis is 9 – 10 visits over a period of 8 weeks, also recommending to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The request for 12 sessions of physical therapy here represent treatment alone which is in excess of the 9- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for myalgias and/or myositis of various body parts. It is further noted that page 99 of the MTUS Chronic Pain Medical Treatment Guidelines endorses fading of treatment frequency and self-directed home physical medicine. Treatment in this overall amount, quantity, frequency is not endorsed in the MTUS. A review of the records indicated that the employee's failure to return to any form of work implies a lack of functional improvement as defined in guidelines section following completion of prior physical therapy. **The request for physical therapy 2 times per week for 6 weeks for the lumbar spine is not medically necessary or appropriate.**

2) Regarding the request for refill prescription for anti-inflammatories (unspecified):

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, page 22, Anti-inflammatory medications, which is a part of the MTUS.

Rationale for the Decision:

According to the Chronic Pain Medical Treatment Guidelines, anti-inflammatory medications represent the traditional first line of treatment. A review of the records indicates in this case, however, the attending provider has failed to clearly state the name of the medication that he is prescribing, refilling, and/or continuing. It is further noted that the employee's failure to return to any form of work implies a lack of functional improvement with prior therapies, including the unspecified anti-inflammatory drug. **The request for refill prescription for anti-inflammatories (unspecified) is not medically necessary or 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, 18th Floor
Oakland, CA 94612

/dat

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.