

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

2278

[Redacted]

Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0021386	<b>Date of Injury:</b>	02/03/1998
<b>Claims Number:</b>	[Redacted]	<b>UR Denial Date:</b>	06/30/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	09/09/2013
<b>Employee Name:</b>	[Redacted]		
<b>Provider Name:</b>	[Redacted] MD		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
PLEASE REFERENCE UTILIZATION REVIEW DETERMINATION LETTER			

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 Emergency Medicine, and is licensed to practice in 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]

### 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 68-year-old male who reported an injury on 02/03/1998. The patient's current diagnoses include postoperative total knee replacement, prosthetic implant failure, low back pain, postlaminectomy syndrome, and weakness. The patient was recently seen by Dr. [REDACTED] on 09/03/2013. The patient was 4 months status post revision of right total knee arthroplasty. It was noted that the patient's knee is functioning well, and the patient no longer reports pain and instability. Physical examination of the right knee revealed 0 degree extension, 120 degrees flexion, intact sensation, 5/5 motor strength, and negative instability. X-rays of the right knee obtained in the office on that date indicated satisfactory alignment. Treatment plan included continuation of the home exercise program.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. 12 physical therapy visits is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 98-99, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS Guidelines state 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. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process in order to maintain improvement levels. Guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. A previous authorization was submitted for 4 sessions of physical therapy for the lumbar spine on 06/30/2013. A physical therapy discharge note was submitted on 09/20/2013, following the patient's completion of 4 sessions of physical therapy for the lumbar spine. The patient reported 4/10 pain at rest and 9/10 pain with activity. Objective findings revealed positive straight leg raising bilaterally, normal strength, and tenderness to palpation. The patient was able to meet all of his short-term treatment goals, and was compliant with a home exercise program. The patient was then discharged from physical therapy services. The patient does not currently demonstrate significant musculoskeletal or neurological deficits that would require skilled physical medicine treatment. The patient is status post L3-4 and L4-5 fusion in 2006. The patient has now completed 4 sessions of physical therapy. The medical necessity for ongoing treatment has not been established. Furthermore, the current request for 12 sessions of physical therapy exceeds guideline recommendations for a total duration of treatment. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

## **2. 1 chair padding is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, DME, which is part of the 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 Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), treatment index, 11<sup>th</sup>. edition (web), 2013, Knee & Leg Chapter, Durable Medical Equipment (DME), which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Official Disability Guidelines state, durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. DME is defined as equipment which can withstand repeated use, could normally be rented, is used by successive patients, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. There is a lack of documentation providing evidence of a functional limitation that would necessitate the requested equipment. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

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]

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