

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/24/2013  
Date of Injury: 12/22/2000  
IMR Application Received: 8/12/2013  
MAXIMUS Case Number: CM13-0010025

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 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]

### 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 55 year old female who reported an injury on 12/22/2000. She has completed 20-30 sessions of physical therapy but has continued to complain of right shoulder pain. According to her physical exam on 06/27/2013, it was noted that she has full symmetrical range of motion, positive impingement, positive painful arc, tender subacromial bursa, and diminished external rotation. A previous MRI, dated 7/12/2010 concluded that there was moderately advanced glenohumeral arthritis, diffuse degeneration of the labrum with probable tears both anteriorly and posteriorly, rotator cuff tendinopathy with no full thickness tear seen and no loose body. On the doctor's report dated 9/09/2013, the patient was noted as having no upper extremity weakness, full range of motion in her cervical spine with no tenderness to the paraspinal area, and a negative Spurling's test. It also noted that although the patient had decreased range of motion in her right shoulder, there was no tenderness with rested shoulder abduction and flexion.

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

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

**1. Physical therapy three times a week for six weeks is not medically necessary and appropriate.**

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

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

The Physician Reviewer's decision rationale:

According to the CA MTUS, active therapy should be set up to allow for fading of treatments after the initial sessions have been completed. The maximum number of sessions allowed by CA MTUS for a patient with unspecified myalgia is 9-10 weeks over an 8 week period and 8-10 visits over a 4 week period for a patient with neuralgia, neuritis or radiculitis. The employee has had more than the maximum allowed sessions. Furthermore, patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As this employee has had numerous visits with the physical therapist, proficiency in appropriate exercises in the home should be expected. **The request for physical therapy is not medically necessary and appropriate.**

**2. The request for TENS unit supplies is not medically necessary and appropriate.**

The Claims Administrator based its decision on the California MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, TENS, pages 114-117, which is a part of the MTUS.

The Physician Reviewer's decision rationale:

According to CA MTUS, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for treatment of neuropathic pain or CRPS Type II. There is no documentation in the medical records provided for review to show that this employee is or has been treated for either of these diagnoses. **The request for TENS supplies is not medically necessary and appropriate.**

**3. An overhead traction unit is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Neck and Upper Back Chapter, which is not a 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Traction.

The Physician Reviewer's decision rationale:

The ODG recommend home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces) for patients with radicular symptoms, in conjunction with a home exercise program. However, according to the documentation dated 9/24/2012, the employee was educated on the use and function of what overhead traction was and it was indicated that the employee did not report significant neck problems. Furthermore, the most current documentation in the clinical records submitted for review dated 8/09/2013 only mentions that one of the chief complaints from repetitive use was neck and upper back pain, but other than that, there is no current information indicating the

employee is still having anything other than shoulder pain. **The request for an overhead traction unit is not medically necessary and appropriate.**

**4. An MRI of the right shoulder is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, which are not a 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder Chapter, MRI.

The Physician Reviewer's decision rationale:

Per the ODG, imaging is indicated for acute shoulder trauma, suspected rotator cuff tear/impingement; a patient over age 40; normal plain radiographs; subacute shoulder pain, and suspected instability/labral tear. According to the medical records provided for review, the employee has not responded to conservative treatment including several sessions of physical therapy as well as medication use. An MRI is found to be medically necessary in determining whether or not the employee is a candidate for surgery. As such, the requested service is certified. **The request for an MRI of the right shoulder is medically necessary and appropriate.**

/dso

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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