

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/7/2013
Date of Injury: 7/16/2012
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011662

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 Orthopedic Surgery, 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 60-year-old female who reported a work related injury on 07/16/2012, as a result of a fall. Subsequently, the patient is status post right shoulder arthroscopic subacromial decompression, Mumford procedure, and microtenotomy as of 03/14/2013. Clinical note dated 06/07/2013 reports the patient was seen in clinic by provider, Dr. [REDACTED]. The provider documented upon physical exam of the patient's right upper extremity, range of motion was noted to be at 130 degrees of forward elevation, abduction of 60 degrees, external rotation at 0 degrees, internal rotation 20 degrees. The provider documented the patient had 9 more approved physical therapy sessions left. The provider documents the patient continues to report diffuse pain in the right arm and weakness of grip. The provider recommended electrodiagnostic studies of the right upper extremity as well as Dyna splint rental for home use to regain shoulder motion.

IMR DECISION(S) AND RATIONALE(S)

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

1. Rental of Dyna to the right shoulder for 90 days is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Dynasplint system, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines, Shoulder Chapter, Dynasplint system, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The current request previously receive and adverse determination; however, previous peer review was not evidenced in the clinical notes reviewed. The employee presented postoperative to a right shoulder arthroscopic repair as of 03/14/2013. The provider documented the employee

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presented with decreased range of motion about the right shoulder. The provider recommended the employee utilize Dyna splint to the right shoulder x90 days; however, documentation of plateau with physical therapy, injection therapy, and other active treatment modalities were not evidenced in the clinical notes reviewed. Official Disability Guidelines indicate, “static progressive stretch therapy is recommended as an option for adhesive capsulitis.” Given the lack of documentation evidencing a plateau with physical therapies and exhaustion of other lower levels of conservative treatment, the current request is not supported. In addition, 90 days is excessive in nature without regular assessments of the employee's reports of efficacy with this intervention. **The request for rental of Dyna to the right shoulder for 90 days is not medically necessary and appropriate.**

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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