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## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/27/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/19/2013  
Date of Injury: 5/1/2011  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0011939

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 PM&R, and is licensed to practice in Pennsylvania. 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 underlying date of injury in this case is 05/01/2011. Other documentation alternatively reports the date as 05/01/2012. The reported mechanism of injury is that the patient had a job involving carrying binders and doing form work and she developed pain in her right shoulder. The patient's diagnosis is shoulder pain.

On 01/17/2013, a right shoulder MRI reported 6 months of right shoulder pain and demonstrated no evidence of a rotator cuff tear. There was moderate evidence of changes of the acromioclavicular joint with lateral downsloping of the acromion. As of 08/23/2013, the treating physician noted the patient had been improving with regard to right upper extremity pain since she started physical therapy. The provider noted the patient had completed three out of six sessions and the patient reported pain was improved by greater than 50% and that deep tissue massage was also very helpful. A recent EMG had shown borderline ulnar neuropathy of the right elbow. That note indicates that the patient would soon be done with her certified six therapy sessions and that the patient would like to proceed with additional sessions and would continue with a home exercise program as well.

The initial physician reviewer indicated that there were not specific deficits or goals to be addressed with additional physical therapy.

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

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

**1. 6 sessions of physical therapy to the right upper extremity including strengthening and edgelow protocol to run concurrently with present physical therapy is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Physical Therapy Guidelines, which is not part of the MTUS.

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

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines section on physical medicine states "*Allow for fading of treatment frequency plus active self-directed home physical medicine.*" The medical records indicate this patient has done well with supervised therapy and was taught a home exercise program. The records and guidelines do not provide a rationale from the provider for specific goals or indications for additional supervised rather than independent home therapy. Therefore, this treatment request is not medically necessary.

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]

CM13-0011939