

**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: 7/30/2013  
Date of Injury: 8/20/2007  
IMR Application Received: 8/19/2013  
MAXIMUS Case Number: CM13-0012804

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]

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## 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 Surgeon has a subspecialty in Shoulder and Elbow Surgery 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 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 an injury on an unknown date. Her diagnoses include left shoulder pain and left shoulder partial rotator cuff tear. Her physical exam findings include left shoulder tenderness and severe pain with attempted range of motion. An MRI was noted to show a full thickness tear supraspinatus tendon, subscapular tendinosis, and oblique tear of tendon insertion, with probable occult superior labral tear.

### 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 for the left shoulder is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder, Physical Therapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale: The Official Disability Guidelines recommend physical therapy for rotator cuff disorders as it can improve short-term recovery and long-term function. However, for the rotator cuff, physical therapy is recommended as 10 visits over 8 weeks, allowing for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical therapy. The medical records provided for review indicates that the employee has a diagnosis of a left partial rotator cuff tear. An MRI was noted to show a full thickness tear supraspinatus tendon, subscapular tendinosis, and oblique tear of tendon insertion, with probable occult superior labral tear. The employee's symptom is left

shoulder pain. Objective findings were noted as left shoulder tenderness and severe pain with attempted range of motion. The employee is noted to have a left shoulder rotator cuff tear and physical therapy would be recommended by the guidelines. However, the request is for physical therapy 3 times per week for 6 weeks which exceeds the number of treatments recommended by the Official Disability Guidelines. **The request for physical therapy three times a week for six weeks for the left shoulder 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]

CM13-0012804