

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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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: 8/8/2013  
Date of Injury: 1/4/2000  
IMR Application Received: 8/20/2013  
MAXIMUS Case Number: CM13-0013782

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 New York and Texas has a subspecialty in Sports Medicine and is licensed to practice in Physical Medicine and Rehabilitation. 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 72-year-old male who reported a work-related injury on 01/04/2000; specific mechanism of injury was not stated. The patient presents with chronic bilateral shoulders, right upper extremity, lumbar spine, and left hip pain. The clinical note dated 07/26/2013 reports the patient is seen under the care of Dr. [REDACTED] for his chronic pain complaints. The patient presents reporting he has persistent pain throughout the left hip, left knee, and right shoulder. The patient also admits to feeling pain when he raises his left shoulder above shoulder level. The provider documents the patient ambulates with a cane and he also utilizes a knee brace and back brace as needed. The provider documents upon physical exam of the patient, the left upper extremity abducts to 110 degrees and right upper extremity abducts to 90 degrees. The left upper extremity extends to 180 degrees and flexes to 90 degrees. The provider documented review of MRI of the left shoulder dated 07/22/2013 which revealed no full-thickness tear and no high grade bursal surface tear of the rotator cuff. The provider documented physical therapy was requested for the purpose of strengthening and pain reduction. The provider documents the patient utilizes Norco 10/325 mg, glucosamine, Metamucil, and Bengay topical ointment, as well as hot and cold modalities.

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

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

**1. Physical Therapy for the left shoulder for twelve session is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS Chronic Pain Treatment Guidelines, page 98-99, which is part of MTUS.

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

The Physician Reviewer's decision rationale:

The current request previously received an adverse determination due to lack of documentation evidencing the employee's reports of efficacy with previous physical therapy (PT), interventions; no specific omission of objective evidence of functional improvement with prior courses of physical therapy. Review of the clinical documentation currently submitted for this specific request lacked documentation evidencing supervised therapeutic interventions have been effective in the past for increasing the employee's range of motion, decreasing the employee's pain on a Visual Analog Scale (VAS), as well as increasing the employee's objective functionality. The employee does present with multiple chronic pain complaints and deficits whereas California MTUS indicates, "Allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active, self-directed home physical medicine." It is unclear when the employee last utilized supervised therapeutic interventions and the efficacy of treatment.

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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