

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/20/2013
Date of Injury:	7/11/2006
IMR Application Received:	8/27/2013
MAXIMUS Case Number:	CM13-0016954

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right shoulder subacromial injection** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/27/2013 disputing the Utilization Review Denial dated 8/20/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right shoulder subacromial injection** is not **medically necessary and appropriate**.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision 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 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 Expert 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

This is a 59-year-old gentleman who was injured on 7/11/06. A recent clinical record for review includes a 8/26/13 progress report indicating current diagnosis of spinal stenosis to the cervical spine, quadriplegia C1 through C4 incomplete, brachial neuritis/radiculitis, and ankylosis of the shoulder region. Subjective complaints at that time state that the claimant's shoulder was hurting and that a request for a shoulder injection had been denied. It states that the current medication regimen is working well with physical examination findings showing the shoulder to be with restricted range of motion to 90° of forward flexion, 80° of abduction, and a positive cross impingement test. The plan at that time was for a shoulder injection of corticosteroid as well as continuation of medication management and continued work restrictions with permanent and stationary restrictions. Clinical imaging regarding the shoulder is unclear. At present, there is a request for a right shoulder injectable. As stated, the last clinical evaluation was supported only by left shoulder physical examination findings. There is no documentation of previous injection therapy to the shoulder noted.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for right shoulder subacromial injection :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines, Shoulder Section, which is not a part of MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg 204, which is part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines support up to three subacromial injections for treatment of symptomatic impingement. The medical records provided for review indicate the last clinical evaluation was supported only by the left shoulder physical examination findings. However, the injection in question would not be supported as there is no clinical correlation between the employee's recent physical examination and the request at present. The request is for a right shoulder injection with physical examination showing left-sided shoulder pain. **The request for right shoulder subacromial injection is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

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.