

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0017594	<b>Date of Injury:</b>	08/18/2008
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/26/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] M.D		

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: PARTIAL OVERTURN. This means we decided that some (but not all) 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 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 45 year old female injured in a work related accident on August 18, 2008. The patient sustained an injury to the right upper extremity. The records indicate that following a course of conservative care a May 2012 right shoulder open subacromial decompression occurred. The postoperative clinical records for review include a recent MRI report February 5, 2013 of the right shoulder showing partial thickness intrasubstance tearing to the mid supraspinatus, prior acromioplasty and no other significant findings. The most recent assessment for review is a PR-2 report July 19, 2013 where the patient saw orthopedic surgeon Dr. [REDACTED] where he noted subjective complaints of right shoulder and right hand pain with a physical examination showing the right shoulder to be with diminished range of motion, positive pain with thumbs down rotator cuff testing and positive Neer and Hawkins impingement testing. The diagnosis was impingement syndrome. At that time the patient was also diagnosed with carpal tunnel syndrome and a cervical strain with positive physical examination findings of Tinel's and Phalen's testing consistent with underlying diagnosis.

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

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

**1. A right shoulder arthroscopic decompression with Mumford procedure and lysis of possible adhesions is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 9, Shoulder Complaints, page 211, which is a part of the MTUS.

The Physician Reviewer based his/her decision on the ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9, Shoulder Complaints, page 211, which is a part of MTUS, as well as the Official Disability Guidelines (ODG) Shoulder procedures, which is not a part of MTUS.

The Physician Reviewer's decision rationale:

Based on the CA ACOEM Guidelines and supported by the Official Guidelines criteria the proposed procedure would not be supported. The clinical guidelines do not recommend the role of surgical intervention for adhesive capsulitis thus negating the need for lysis of adhesions procedure. Additionally, the employee's physical examination fails to demonstrate specific range of motion findings to necessitate any surgical or anesthetic process for a lysis of adhesion. In regards to the Mumford procedure, the employee's physical examination and imaging are silent regarding acromioclavicular joint findings. The absence of physical examination findings at the acromioclavicular joint coupled with no documentation of findings on MRI report of a degenerative process or inflammatory process at the acromioclavicular joint would not support a medical necessity for the requested Mumford procedure. The surgical request would not be indicated. **The request for a right shoulder arthroscopy with Mumford procedure and lysis of adhesions is not medically necessary and appropriate.**

**2. The prescription for ibuprofen 600mg #60 is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are a part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, pages 67-68, which is a part of MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Medical Treatment Guidelines, continued use of ibuprofen would be medically necessary. The aforementioned surgery is not indicated; however, the employee is with a clearly documented inflammatory process on physical examination and has subjective complaints consistent with the exam; the continued role of nonsteroidal medication appears to be medically necessary. **The request for ibuprofen 600mg #60 is medically necessary and appropriate.**

**3. Physical therapy (8 sessions) is not medically necessary and appropriate.**

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99, which is a part of MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Guidelines, eight sessions of physical therapy would not be indicated. The employee's treatment at this time could be directed in a home exercise program and the employee should be well versed in this type of program at this stage of the clinical course. The physical therapy in light of the employee's current findings and absent indication for surgical process would not be supported. **The request for 8 sessions of physical therapy is not medically necessary and appropriate.**

/dso

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]

CM13-0017594