
Notice of Independent Medical Review Determination

Dated: 8/26/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/5/2013

6/6/1997

7/10/2013

CM13-0001175

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 6 times per week for 6 weeks **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/10/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/11/2013. 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 physical therapy 6 times per week for 6 weeks **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 Physical Medicine and Rehabilitation, 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 5, 2013

" This is a 58 year old female agricultural inspector with a date of injury of 6/6/1997. Exam on 6/26/13 patient is 6 weeks s/p right shoulder open RTC repair. She is in physical therapy and is doing well. Exam revealed tenderness anterior deltoid. Sensation/motor is noted as 5/5. ROM is noted with abduction flexion at 180 degrees, extension and IR at 80 degrees. Diagnoses include right shoulder rotator cuff tear, s/p open repair and subacromial decompression."

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 for Independent Medical Review (dated 7/10/2013)
- Utilization Review from [REDACTED] (dated 7/5/2013)
- Medical Records from [REDACTED], Dr. [REDACTED] (dated 5/7/12-7/2/13)
- Job Description Report from Employee (dated 7/24/12)
- Medical Records from [REDACTED] (date 7/27/12)
- Medical Records from [REDACTED], MD (dated 7/24/12-12/21/12)
- Medical Records from [REDACTED] (dated 9/7/12-9/17/12)
- Medical Records from [REDACTED] (dated 2/19/13)
- Medical Records from [REDACTED] (dated 4/6/13)
- Medical Records from [REDACTED] (dated 5/19/13)
- Post Surgical Treatment Guidelines Evidence Based Reviews (May, 2009) Shoulder Complaints

1) Regarding the request for physical therapy 6 times per week for 6 weeks:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Post Surgical Treatment Guidelines (May, 2009), Shoulder Complaints, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury to the right shoulder on 6/6/97. Medical records provided for review indicate a right shoulder open rotator cuff repair on 4/26/13. The request is for physical therapy, six (6) times a week for six (6) weeks.

MTUS Postsurgical Treatment Guidelines indicate continuation of physical therapy is based on functional improvement. The shoulder range of motion findings from the medical record of 6/26/13 indicate identical measurements to the preoperative range of motion documented on 3/18/13. The guidelines allow for 30 visits over 18 weeks for an open right shoulder decompression, and continuation beyond that amount would only be indicated by documented functional improvement. Criteria for continued physical therapy have not been met. The request for physical therapy, 6 times a week for 6 weeks, **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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

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

/dl

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.