
Notice of Independent Medical Review Determination

Dated: 9/18/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/3/2013
Date of Injury: 10/13/2010
IMR Application Received: 7/18/2013
MAXIMUS Case Number: CM13-0001862

- 1) MAXIMUS Federal Services, Inc. has determined the requested physical therapy post-op right shoulder (frequency and duration not listed) **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 requested physical therapy post-op right shoulder frequency and duration not listed **is 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 3, 2013:

"This patient injured her right shoulder, left shoulder, cervical spine and both lower extremities in October, 2010. She had therapy to all areas. In January 2012, she had a QME with Dr. [REDACTED]. He opined that the patient needed an MRI of the right knee and shoulder. The patient was seen by Dr. [REDACTED], physical medicine physician, on February 6, 2013. His report is hand written and difficult to read. He does note a positive impingement sign on the right and a decreased range of motion. The patient was seen by an Orthopedist, Dr. [REDACTED] on February 4, 2013. He noted that the patient had had an ultrasound of the right shoulder on December 4, 2011 that reveal subacromial impingement syndrome, intrasubstance tearing/tendinosis of the supraspinatus portion of the rotator cuff. She also had a narrowing of the subacromial space and bursitis. She subjectively reported tenderness, stiffness and weakness of the right shoulder with a pain level of 10/10. On physical examination, she has a slight decrease of range of motion of the right shoulder in multiple directions. She had tenderness in the supraspinatus area and in the greater tuberosity. She had positive acromioclavicular joint compression, impingement I and Impingement II and Impingement II tests. She had a negative Speed and O'Brien tests. She had normal strength. She had normal reflexes. Dr. [REDACTED] requested arthroscopic evaluation to be followed by an arthroscopic decompression, possible distal clavicle resection, rotator cuff debridement and/or repair as indicated. This was reportedly done on April 10, 2013 by Dr. [REDACTED]. The patient was seen by Dr. [REDACTED] on June 3, 2013. He is requesting additional physical therapy to the right shoulder, not frequency or duration 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 for Independent Medical Review (dated 7/18/2013)
- Utilization Review from [REDACTED] (dated 7/3/2013)
- Medical Records from [REDACTED], MD (dated 8/16/12)
- Medical Records from [REDACTED] (dated 2/4/13-7/5/13)
- Medical Records from [REDACTED] (dated 4/30/13)
- Medical Records from [REDACTED] (dated 5/20/13-5/24/13)
- Post Surgical Treatment Guidelines (MTUS) Post-Surgical Patient Management

1) Regarding the request for Physical therapy post-op Right shoulder frequency and duration not listed:**Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:**

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), postsurgical treatment guidelines, 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 an injury on 10/13/10 to the right shoulder, cervical spine, and both lower extremities. The medical records provided for review found the employee to have right shoulder impingent syndrome and partial tear of the supraspinatus portion of the rotator cuff. Treatment has included post-operative physical therapy. The medical report of June 3, 2013 documents the employee had completed 3 physical therapy sessions, and the plan was to continue with the remaining previously authorized post-operative therapy sessions. The request is for physical therapy post-op right shoulder (frequency and duration not listed).

MTUS guidelines recommend an initial course of therapy which is half of the general course of 24 visits for post-surgical rotator cuff/impingement syndrome. The medical records provided for review indicate five physical therapy sessions have been completed between 5/24/13 and 6/7/13. This does not exceed the MTUS initial course of therapy per the guidelines. The request for physical therapy post-op right shoulder (frequency and duration not listed) is 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
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/sce

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.