
Notice of Independent Medical Review Determination

Dated: 10/3/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	7/22/2009
IMR Application Received:	7/18/2013
MAXIMUS Case Number:	CM13-0001988

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 3 times a week for 6 weeks for the left elbow, bilateral shoulders, midback, and neck **is not 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 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 3 times a week for 6 weeks for the left elbow, bilateral shoulders, midback, and neck **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 Occupational Medicine 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:

“Claimant is a 55 year old who allegedly sustained an industrial injury on 07/22/09. Mechanism of injury is not documented. Diagnoses are listed as cervical strain, thoracic strain, possible bilateral shoulder impingement, left elbow medial and lateral epicondylitis, and bilateral carpal tunnel syndrome. 06/17/13 physical therapy note indicated that claimant had completed 14 PT sessions, with improvements in pain and mobility. However, claimant reported that effects of therapy did not last. 07/03/13 provider note stated that claimant was going to therapy and that this was helping. Claimant reported 7/10 neck pain, 9-10/10 mid back pain, 8/10 right shoulder pain, 10/10 left shoulder pain, 7-8/10 right wrist/hand pain, 5-6/10 neck pain, and 8-9/10 left wrist/hand pain. Bilateral muscle spasm and tenderness over the trapezius muscles, medial epicondyles, and lateral epicondyles was noted. 06/06/12 upper extremity electrodiagnostic studies had been consistent with mild bilateral carpal tunnel syndrome.”

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:

- Applicant for Independent Medical Review (received 07/18/2013)
- Utilization Review for Determination from [REDACTED] (dated 07/05/2013)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for physical therapy 3 times a week for 6 weeks for the left elbow, bilateral shoulders, midback, and neck:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (May, 2009) pg. 98-99, 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 on July 22, 2009 to the right and left shoulders, mid-back, neck, left elbow, and the right and left wrists. The medical records provided for review indicate a diagnosis of cervical strain with possible degenerative disc disease, thoracic strain, possible bilateral shoulder impingement, left elbow epicondylitis (tennis elbow), and bilateral carpal tunnel syndrome. The medical report of July 3, 2013 documents that the employee reported 7/10 neck pain, 9-10/10 mid-back pain, 8/10 right shoulder pain, 10/10 left shoulder pain, 7-8/10 right wrist/hand pain, 5-6/10 neck pain, and 8-9/10 left wrist/hand pain. There was a report of persistent neck pain that is increased with prolonged sitting and activities of daily living, right and left shoulder pain and hand pain, and the dropping of objects. Treatments have included physical therapy, right and left wrist splints, and non-steroidal anti-inflammatory drugs (NSAIDs). The request is for physical therapy three (3) times a week for six (6) weeks for the left elbow, bilateral shoulders, mid-back, and neck.

The MTUS Chronic Pain Guidelines indicate that passive therapies may have some use in the acute phase of injury, but should be used sparingly with education on active exercise that are to be repeated in an active self-directed plan for rehabilitation. The medical records reviewed indicate that the amount of physical therapy sessions the employee has already received is in excess of recommended guideline amounts with no documentation to support additional therapy outside guideline criteria. The request for physical therapy 3 times a week for six (6) weeks for the left elbow, bilateral shoulders, mid-back, and neck **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
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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.