

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: 10/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/10/2013
Date of Injury:	6/2/2012
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003642

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy two (2) times a week for four (4) weeks for the right shoulder **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/5/2013. 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 two (2) times a week for four (4) weeks for the right shoulder **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The 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 Preventative Medicine & 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 10, 2013:

“The claimant has had persistent/recurrent pain since the date of injury of 6/2/12 with regards to both shoulders. The claimant is planning to undergo a left distal open clavicle resection to treat recurrent symptoms related to the left shoulder. The claimant is noted to be currently prescribed Vicodin and Xanax on a regular basis. The claimant's shoulder pain on both sides is noted to be 7/10 on a visual analog scale. The right shoulder range of motion is noted to be essentially full except for slightly limited external rotation. There was a positive impingement sign on the right with AC tenderness and intact strength. Impression included shoulder AC osteoarthritis.”

### **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
- Utilization Review Determination from Claim Administrator
- Employee medical records from Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) **Regarding the request for physical therapy two (2) times a week for four (4) weeks for the right shoulder:**

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

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Shoulder Disorders Chapter, which is part of the California Medical Treatment Utilization Schedule (MTUS), but did not cite a specific page. The Claims Administrator also cited the Chronic Pain Medical Treatment Guidelines (2009), which are part of the MTUS, but did not cite a specific section. The Claims Administrator further cited the Official Disability Guidelines (ODG), which is a medical treatment guideline that is not part of the MTUS, but did not cite a specific section. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), pages 8 and 99, which are part of the MTUS. The Expert Reviewer also cited ACOEM, Chapter 3, which is part of the MTUS.

Rationale for the Decision:

The employee was injured on 6/2/2012 and has experienced bilateral shoulder pain and shoulder osteoarthritis. Treatment has included the following: analgesic medications; adjuvant medications; psychotropic medications; left shoulder distal clavicle surgery; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy; and extensive periods of time off of work, and total temporary disability status. A request was submitted for physical therapy two (2) times a week for four (4) weeks for the right shoulder.

The MTUS Chronic Pain guidelines recommend fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified 9-10 visits over 8 weeks, and demonstration of functional improvement is necessary at various milestones in the functional restoration program in order to justify continued treatment. Medical records submitted and reviewed indicate the employee has had prior unspecified amounts of physical therapy over the life of the claim with no evidence of functional improvement, improved performance of activities of daily living and/or diminished reliance on medical treatment. The employee is pursuing further surgery which suggests the failure of prior physical therapy. The guideline criteria have not been met. The request for physical therapy two (2) times a week for four (4) weeks for the right shoulder **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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.