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**Notice of Independent Medical Review Determination**

Dated: 11/26/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	4/3/2013
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004093

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one ultrasound study of the right shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **twelve post-operative physical therapy sessions is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/6/2013. 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 **one ultrasound study of the right shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **twelve post-operative physical therapy sessions 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 Preventive Medicine and 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.

### Expert Reviewer Case Summary:

**CLAIMANT:** [REDACTED]

**CLINICAL SUMMARY:** All 238 pages of medical, insurance, and administrative records provided were reviewed.

The claimant, Mr. [REDACTED], is a represented resident manager, who has filed a claim for closed fracture of the wrist (radius and scaphoid bones) reportedly associated with an industrial injury of April 3, 2013.

Thus far, he has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; a CT scan of the injured hand and wrist of April 5, 2013, notable for scapholunate dissociation and possible radial styloid fracture; a cast; transfer of care to and from various providers in various specialties; unspecified wrist surgery; incision and drainage of a postoperative right neck abscess; and extensive periods of time off of work.

A recent progress report of July 18, 2013 is notable for comments that the applicant still reports persistent wrist pain. Still he reports persistent right shoulder clicking and catching. He is pending an ultrasound study of the shoulder, is diabetic, and exhibits significantly limited right shoulder range of motion with flexion to 95 degrees and abduction to 85 degrees. The applicant is asked to pursue additional physical therapy for the neck and thoracolumbar spine while remaining off of work, on total temporary

disability. An ultrasound of the shoulder is sought to determine integrity of the rotator cuff structures.

He remains off of on work, on total temporary disability. He has failed to improve in terms of work status, work restrictions, activities of daily living, and/or diminished reliance on medical treatment. His ongoing complaints of pain, significantly diminished shoulder range of motion, and transfer of care to and from/consultation with numerous providers in numerous specialties all argue against any diminished reliance on medical treatment. Therefore, the request is non-certified owing to lack of functional improvement as defined in section 9792.20f.

**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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for one ultrasound study of the right shoulder:**

Section of the Medical Treatment Utilization Schedule 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 Complaints, Chapter 9, pg. 214, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Shoulder Complaints, Chapter 9, table 9-6, which is a part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 9, table 9-6, ultrasonography is not recommended for evaluation of rotator cuff integrity. Therefore, the request is non-certified, given the unfavorable ACOEM recommendation. **The request for one ultrasound study of the right shoulder is not medically necessary or appropriate.**

**2) Regarding the request for twelve post-operative physical therapy sessions:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (current version), Shoulder (acute and chronic), which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, which is a part of the MTUS.

Rationale for the Decision:

As noted in MTUS 9792.24.3.c.4.b, in cases where no functional improvement is demonstrated, postsurgical treatment may be discontinued at any point during the postsurgical treatment. In this case, the employee is still within the six-month postsurgical window established in MTUS 9792.24.3. He has, however, failed to demonstrate any evidence of functional improvement following completion of the same. **The request for twelve post-operative physical therapy sessions 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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Oakland, CA 94612

/ejf

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.