

**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: 12/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	3/27/2013
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005825

- 1) MAXIMUS Federal Services, Inc. has determined the request for **orthopedic consult, right shoulder surgery is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10mg is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy two times a week for six weeks, right shoulder is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/10/2013. 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 **orthopedic consult, right shoulder surgery is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ambien 10mg is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy two times a week for six weeks, right shoulder 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 Orthopedic Surgery, 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:**

The patient is a 36-year-old male, who reported an injury on 03/27/2013 when sliding a heavy box from a pallet to pallet, causing a pop in his shoulder. The patient was treated with medications, to include Etodolac extended release 600 mg twice a day, 500 mg of acetaminophen 1 to 2 tablets every 8 hours, and 800 mg of metaxalone once at bedtime. The patient also received a course of acupuncture. The patient reported a pain level of 7/10. Physical findings included tenderness to palpation anteriorly and posteriorly to the right shoulder, restricted range of motion of 130 degrees in flexion and 40 degrees in extension, 120 degrees in abduction with a positive Neer's sign, and a positive drop arm sign. The patient was diagnosed with calcifying tendonitis of the shoulder. The patient's treatment plan included medications, acupuncture, physical therapy, and injection therapy.

### **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 orthopedic consult, right shoulder surgery:**

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 Occupational Medicine Practice Guidelines: Evaluation and Management of Common Health Problems and Functional Recovery in Workers, 2<sup>nd</sup> Edition (2004), Chapter 7, pg. 127, which is not part of MTUS, and Chronic Pain Medical Treatment Guidelines, which is part of MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) page 209, which is part of the MTUS.

Rationale for the Decision:

The MTUS ACOEM guidelines, Chapter 9, recommend surgical consultation for individuals who have red flag conditions, have failed to progress in a strengthening program, and have evidence of a surgical lesion. The guidelines indicate that evidence of a lesion and activity limitations greater than 4 months due to a lesion would benefit from surgical intervention. The clinical documentation submitted for review does not support that the employee has any red flag conditions or has failed to respond to a strengthening program. The clinical documentation noted that the employee has had previous physical therapy; however the efficacy of that therapy was not provided. Additionally, there were no diagnostic or imaging studies provided to support a lesion that would require surgical intervention. The clinical documentation also noted that the employee has previously received an orthopedic consultation. There is no documentation that the employee has received any conservative treatment or developed any issues that would require any additional surgical consultations. As such, the requested orthopedic consult for the right shoulder surgery is not recommended. **The request for orthopedic consult, right shoulder surgery is not medically necessary and appropriate.**

**2) Regarding the request for Ambien 10mg:**

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 Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Pain Chapter, section Zolpidem, which is not part of the MTUS.

Rationale for the Decision:

Official Disability Guidelines (ODG) recommend the use of Ambien 10 mg for a short course of treatment for pain-related insomnia. The clinical documentation submitted for review noted that the employee has sleep disturbances due to shoulder pain and weakness. However, the clinical documentation does not provide any objective evaluation of the employee's sleep disturbances. Therefore, the efficacy of this medication cannot be established. Additionally, there is no documentation that the employee is not responding to pain medications. Therefore, there is no support that the employee's sleep disturbances are pain-related. As such, the requested Ambien 10 mg is not recommended. **The request for Ambien 10mg is not medically necessary and appropriate.**

**3) Regarding the request for physical therapy two times a week for six weeks, right shoulder:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, section Physical Medicine, pg. 98-99, which is part of MTUS.

Rationale for the Decision:

The employee does have deficits that would benefit from a course of physical therapy. The MTUS guidelines do recommend physical medicine to restore function and address pain and would support 9-10 sessions for myalgia and myositis. The documentation submitted for review recommended the employee to continue physical therapy; however, there is no evidence of objective functional gains to support continuation of this treatment modality. Also, there is no indication of the frequency or duration of the previous physical therapy to establish that additional physical therapy would be appropriate. As such, the requested physical therapy for the right shoulder is not indicated. **The request for physical therapy two times a week for six weeks, 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,

Paul Manchester, MD, MPH  
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.