

---

## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/30/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/24/2013  
Date of Injury: 3/29/2011  
IMR Application Received: 8/5/2013  
MAXIMUS Case Number: CM13-0006690

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 41 YO, M with a date of injury on 3/29/11. The patient's diagnoses include: C/S sprain/strain; bilateral shoulder sprain/strain/impingement; bilateral wrist/hand tenosynovitis. According to the utilization review letter dated 7/24/13 by Dr. [REDACTED] the AME report dated 6/18/13 by Dr. [REDACTED] noted that the left shoulder MRI dated 5/31/12 documented moderately severe impingement syndrome, tendinosis of the rotator cuff with a tear predominantly to the supraspinatus tendon. Right shoulder and post-op PT was recommended. The progress report dated 6/26/13 by Dr. [REDACTED] noted that the MRI dated 3/29/13 documented full thickness tear of the supraspinatus tendon. The patient remains symptomatic in both shoulders despite non operative treatment. He has been evaluated by QME and surgery has been recommended on the right shoulder since 2012 and on the left shoulder in 2013. Based on the imaging findings the proposed surgery would be considered medically necessary. However, neither the QME nor the office note of the treating provider include a description of the current symptoms and physical findings, therefore the requested bilateral shoulder surgeries and post-op PT sessions were non-certified.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

**1. Twelve (12) sessions of physical therapy for bilateral shoulders three (3) times a week for four (4) weeks is not medically necessary and appropriate.**

The Claims Administrator based its decision on the (ACOEM) Occupational Medicine Practice Guidelines, 2<sup>nd</sup> edition (2008), Shoulder Complaints, pgs 560-561, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Post-Surgical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer's decision rationale:

According to the utilization review letter dated 7/24/13, by Dr. [REDACTED] states the patient remains symptomatic in both shoulders despite non operative treatment. He has been evaluated by QME, and surgery has been recommended on the right shoulder since 2012, and on the left shoulder in 2013. Based on the imaging findings the proposed surgery would be considered medically necessary. However, neither the QME nor the office note of the treating provider includes a description of the current symptoms and physical findings, therefore the requested bilateral shoulder surgeries and post-op PT sessions were non-certified. The postsurgical treatment guidelines for rotator cuff syndrome/impingement syndrome supports the requested 12 sessions of post-op PT visits ("initial course of therapy" means ½ of the number of visits specified in the general course of therapy for the specific surgery: 24 visits over 14 weeks). However, the requested bilateral shoulder surgeries were not certified, therefore recommendation is for denial.

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.

[REDACTED]  
[REDACTED]  
[REDACTED]

CM13-0006690