

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 8/13/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

4/18/2013

3/20/2013

4/29/2013

CM13-0000268

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical medicine and rehabilitation consult and treatment **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/29/2013 disputing the Utilization Review Denial dated 4/18/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/1/2013. 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 medicine and rehabilitation consult and treatment **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 April 18, 2013

“This patient is a 54 year old, right hand dominant, female (Ht: 69 in., Wt: 135 lbs.) who sustained injury to bilateral shoulder, bilateral arm and back after the repetitive lifting of packages. Treatment has consisted of medications, x-ray of bilateral shoulder (negative), education on use of hot/cold packs, and physical therapy x6. Patient is currently working modified duties.

“4/10/13 PR-2 notes the patient has not significantly improved since last visit. Patient states treatment outlined previously has been followed and tolerated. Patient complains of bilateral shoulder pain and described pain as dull, moderately severe and has had symptoms for 21 days. Patient reports no numbness, tingling or radiation, weakness, and no pain at wrist/hand/fingers. Complains of pain with ROM and restricted ROM. Pain is rated 4/10. On examination of left shoulder, tenderness noted to left deltoid muscle and full ROM noted. Right shoulder examination reveals full ROM and no tenderness present. Physician states there is no improvement in bilateral shoulder pain. patient does not want to drive 65 miles here for acupuncture and is not working due to restrictions.” Physician is requesting a transfer of care to a PM&R due to a failure in progress.”

### 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 (received 4/29/13)
- Utilization Review Determination (dated 4/18/13)
- Employee medical records from [REDACTED] (dated 3/22/13-5/3/13)
- Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9), 201-204

**1) Regarding the request for physical medicine and rehabilitation consult and treatment:**

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

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9), 204-208, 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 stated MTUS, including the guidelines used by the Claims Administrator, does not specifically address the issue at dispute and based his/her decision on ACOEM, Third Edition (2010) Chronic Pain, Summary of Recommendations, Evaluation chapter, which is not part of MTUS, as relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained an industrial injury on March 20, 2013, resulting in bilateral shoulder pain, bilateral arm pain, and back pain. Treatment has consisted of analgesic medications, topical agents, initial return to restricted duty with 5 and 10 pound lifting limitations, and topical applications of heat and cold. The most recent progress report of May 3, 2013, indicates the employee reports diminished pain about the bilateral shoulders, is working regular duty, and exhibits full range of motion with no tenderness to touch about either shoulder, and that the employee is released from care with no limitations or restrictions.

The MTUS does not specifically address the issue at dispute. The ACOEM Chronic Pain Guidelines (2010), Evaluation chapter, states that consultation with other providers in other specialties, including physiatry, is indicated and appropriate if there is evidence of delayed recovery, compromise in the applicant's function, and/or a lack of diagnostic clarity. The records provided for review show no indication that the applicant suffers from any issues related to chronic pain, delayed recovery, lack of diagnostic clarity, etc., and specifically state the employee has been released from care with return to full duty. The physical medicine and rehabilitation consult and treatment **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.