
Notice of Independent Medical Review Determination

Dated: 10/15/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]
5/14/2013

3/2/2013

5/31/2013

CM13-0000539

- 1) MAXIMUS Federal Services, Inc. has determined the request for Terocin **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for physical therapy three times a week for four weeks **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for rehabilitation therapy two times a week for four weeks **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 5/31/2013 disputing the Utilization Review Denial dated 5/14/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 Terocin **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for physical therapy three times a week for four weeks **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for rehabilitation therapy two times a week for four weeks **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 Physical Medicine and Rehabilitation 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 May 14, 2013

“This is a 35-year-old female who was injured on 3/2/13. The mechanism of injury occurred when she was tugging on heavy laundry that was knotted together, and she strained her right shoulder. Her diagnoses were right shoulder strain and rotator cuff strain with associated rhomboid strain. The clinical report dated 5/9/13, noted she was seen for evaluation under the care of Dr. [REDACTED]. The patient complained of right shoulder and scapula pain. The physical exam of the right shoulder noted forward flexion was 130 degrees, abduction 160 degrees, and adduction 120 degrees. She had a negative crossover test and pain with Hawkin's sign. X-rays of the right shoulder noted a type I acromion. The treatment plan included a request for rehabilitation therapy 2 times 4, physical therapy 3 times 4, initiate Terocin, and consider MRI and surgery if no improvement was noted. The provider documented NSAIDs and Naproxen were not refilled on this date.”

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 05/31/2013)
- Utilization Review Determination from [REDACTED] (dated 05/14/2013)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Terocin:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Pages 111-113, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 3/2/2013 and diagnosed with right shoulder strain and rotator cuff strain with associated rhomboid strain. Treatment to date has included six sessions of physical therapy and medication. The request is for Terocin.

The MTUS Chronic Pain guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical records submitted and reviewed do not show any failed trials of these types of medications. The guideline criteria have not been met. The request for Terocin is not medically necessary and appropriate.

2) Regarding the request for physical therapy three times a week for four weeks:

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), 2nd Edition, (2004), Chapter 9, Pages 201-203, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pages 98-99, which are part of the MTUS.

Rationale for the Decision:

The employee was injured on 3/2/2013 and diagnosed with right shoulder strain and rotator cuff strain with associated rhomboid strain. Treatment to date has

included six sessions of physical therapy and medication. The request is for physical therapy three times a week for four weeks.

The MTUS Chronic Pain guidelines recommend 8-10 visits of physical medicine. The medical records submitted and reviewed showed that the patient received 6 sessions of physical therapy during the preceding month of the request with minimal improvement. The request for 12 physical therapy visits exceeds the guidelines. The request for physical therapy three times a week for four weeks is not medically necessary and appropriate.

3) Regarding the request for rehabilitation therapy two times a week for four weeks:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter. The provider also did not cite a guideline. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines (2009), Physical Medicine, pages 98-99, which are part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 3/2/2013 and diagnosed with right shoulder strain and rotator cuff strain with associated rhomboid strain. Treatment to date has included six sessions of physical therapy and medication. The request is for rehabilitation therapy two times a week for four weeks.

The MTUS Chronic Pain guidelines recommend 8-10 visits of physical medicine. Medical records submitted and reviewed document the patient has recently completed 6 sessions of physical therapy with minimal improvement. An additional 8 sessions of physical medicine would exceed the recommended 8-10 visits. The request for rehabilitation therapy two times a week for four weeks 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, 18th Floor
Oakland, CA 94612

/ldh

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.