

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/4/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	5/31/2013
Date of Injury:	1/24/2013
IMR Application Received:	6/10/2013
MAXIMUS Case Number:	CM13-0000630

- 1) MAXIMUS Federal Services, Inc. has determined the request for physical therapy 3 times a week for 4 weeks to the right shoulder and wrist Qty 12 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/8/2013. 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 therapy 3 times a week for 4 weeks to the right shoulder and wrist Qty 12 **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:**

The applicant, Ms. [REDACTED], is a represented 59-year-old housekeeper who has filed a claim for right shoulder, right arm, ribs, right knee, and neck pain reportedly associated with a trip and fall industrial contusion injury of January 24, 2013.

Thus far, she has been treated with the following: Analgesic medications; at least 12 sessions of physical therapy to date; x-rays of the injured body parts, reportedly negative for fracture; and reported return to restricted duty work.

A prior utilization report of May 31, 2013 is notable for comments that the applicant has had six sessions of physical therapy to date and the six further treatments are partially certified.

The most recent clinical note of April 29, 2013 is notable for the comments that the applicant reports persistent knee, wrist, elbow, and shoulder pain. The applicant exhibits significant limitation of shoulder range of motion with abduction to 90 degrees. Wrist range of motion and swelling is also appreciated. The applicant is given prescriptions for Motrin and Robaxin while returning to modified duty work with a 10-pound lifting limitation.

A later physical therapy note of May 22, 2013 suggested that the applicant's shoulder range of motion again remains significantly limited with abduction and flexion 65- to 85-degree range.

### **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 [REDACTED]
- Medical Records from Provider
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for physical therapy 3 times a week for 4 weeks to the right shoulder and wrist Qty 12 :**

#### 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 Forearm, Wrist, and Hand Complaints Chapter (ACOE Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11, page 265, the Chronic Pain Medical Treatment Guidelines, Functional improvement measures, page 48, which are part of the MTUS, and the Official Disability Guidelines (ODG), Hand Section, Physical/Occupational Therapy Guidelines, which is not part of the MTUS.

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

#### Rationale for the Decision:

The MTUS Chronic Pain Guidelines recommend 9 to 10 visits for myalgias and/or myositis of various body parts. The guidelines indicate that there should be demonstration of functional improvement so as to justify continued treatment. The medical records reviewed do not provide evidence of functional improvement through completion of the 6 to 12 prior sessions of physical therapy. The records indicate the employee has failed to demonstrate functional improvement as defined in MTUS section 9792.20 (f) in terms of work status, work restrictions, activities of daily living, and/or diminished reliance on medical treatment. The employee's lack of improvement in terms of shoulder motion and proscriptive functional limitation of no lifting more than 10 pounds argue against any functional improvement to date. It does not appear, moreover, that the employee has returned to the attending provider for reevaluation after completion of the six sessions previously partially certified by the claims administrator. **The request for physical therapy 3 times a week for 4 weeks to the right shoulder and wrist (quantity 12) 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.