

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
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(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested Physical Therapy, two (2) times per week for four (4) weeks, for right shoulder **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/13/2013 disputing the Utilization Review Denial dated 6/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/14/2013. 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 requested Physical Therapy, two (2) times per week for four (4) weeks, for right shoulder **is not medically necessary and appropriate.**

Medical Qualifications of the Professional 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 professional 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 June 3, 2013

“Clinical summary: According to the Consultation Note dated 05/22/13 by Dr. [REDACTED], the patient complained of right shoulder pain. The pain was described as aching and stabbing with pain level of 6-7/10. On examination, there was crepitus upon range of motion, active and passive in the right shoulder. Drop-arm sign was positive on the right with some pain on palpation of the rotator cuff tendons. The patient was diagnosed with right shoulder strain and probably rotator cuff tendinopathy. Date of injury: 02/07/13 Mechanism of injury: The patient was working, changing oil filter and stool slipped out from under, and the patient developed immediate right shoulder and arm pain and neck pain.”

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 6/13/13)
- Utilization Review determination (dated 6/3/13)
- Employee medical records from [REDACTED], DO (dated 5/22/13)
- Employee medical records from [REDACTED] (dated 2/7/13)
- Employee medical records from [REDACTED] (dated 2/14/13-5/5/13)
- Employee medical records from [REDACTED] (dated 2/27/13-3/25/13)

- Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation and Official Disability Guidelines References (May, 2009), pg. 99

1) Regarding the request for Physical Therapy two (2) times per week for four (4) weeks for right shoulder:

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

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines – Division of Workers' Compensation and Official Disability Guidelines References (May, 2009), pg. 99, which is part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee experienced a work-related fall on 2/7/13, injuring the right shoulder, arm, and neck. Medical records provided and reviewed indicate X-rays were taken with normal results. Treatment has included physical therapy for which medical records note steady progress but that pain and symptoms continued. The record of 5/22/13 indicates an orthopedic consult which also noted persistent aching, stabbing right shoulder pain, crepitus on range of motion, positive drop arm test, and tenderness to the rotator cuff tendons. The employee is now more than five (5) months post injury, and pain has continued beyond the anticipated time for healing, meeting the criteria for chronic pain.

MTUS Chronic Pain Guidelines indicate that physical medicine treatment frequency should decrease and a self-directed home exercise program should be the goal. The employee has had extensive therapy without improvement of the pain. According to the guidelines, the completed physical therapy should have been adequate to improve functionally and transition to a home exercise program. Documentation of functional improvement is necessary for the consideration of additional physical therapy. Criteria for additional physical therapy have not been met. The physical therapy visits, two (2) times per week for four (4) weeks, for right shoulder, **are 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

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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.