

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 10/24/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/3/2013
Date of Injury:	9/26/2012
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0003027

- 1) MAXIMUS Federal Services, Inc. has determined the request for post-operative physical therapy left shoulder times 24 visits **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for post-operative CTU **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 post-operative physical therapy left shoulder - 24 visits **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for post-operative CTU **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The 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 Orthopedic Surgery 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 utilization review determination did not contain a clinical summary**

### **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 (dated 07/24/2013)
- Utilization Review Determination from [REDACTED] (dated 07/03/2013)
- Employee medical records from [REDACTED] (dated 08/09/2013)
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request** post-operative physical therapy left shoulder times 24 visits :

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

The Claims Administrator based its decision on Post-Surgical Treatment Guidelines, Shoulder, (page not cited), part of the MTUS. The Expert Reviewer found the Postsurgical Guidelines, Rotator cuff syndrome/Impingement

syndrome, page 28, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the left shoulder on 9/26/2012. The submitted and reviewed clinical records indicate that the employee has had medications and a left shoulder steroid injection. The most recent submitted record, dated 7/08/2013, indicated that the employee continued to have pain in the left shoulder and was seen for a left shoulder surgical consultation. A request was submitted for post-operative physical therapy left shoulder - 24 visits and post-operative cold therapy unit (CPU).

The MTUS Postsurgical guidelines indicate 24 postoperative visits are recommended as the general course of physical therapy for this specified surgery in the postoperative phase of physical therapy for the left shoulder following decompression and clavicle excision. However, the guidelines indicate that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. The request for 24 physical therapy visits postoperatively for the left shoulder exceeds the recommendation of the guidelines for the initial postoperative course of therapy. The request for post-operative physical therapy left shoulder - 24 visits **is not medically necessary and appropriate.**

**2) Regarding the request for post-operative CTU:**

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) guidelines, (2004), 2<sup>nd</sup> Edition, Chapter 9, page 203, part of the MTUS, and the Official Disability Guidelines, (ODG), Current Version, Shoulder Section, a medical treatment guideline (MTG), not part of the MTUS. The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Shoulder Chapter, (Current Version), Continuous Flow Cryotherapy, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the left shoulder on 9/26/2012. The submitted and reviewed clinical records indicate that the employee has had medications and a left shoulder steroid injection. A medical report dated 7/08/2013, indicated that the employee continued to have pain in the left shoulder and was seen for a left shoulder surgical consultation. A request was submitted for post-operative physical therapy left shoulder - 24 visits and post-operative cold therapy unit (CTU).

The Official Disability Guidelines indicate that cold therapy units, or continuous flow cryotherapy, may be recommended as an option following surgical treatment, however, not as a nonsurgical treatment. Postoperative use is

generally indicated for up to 7 days including home use. The current request for a postoperative CTU fails to detail the length of time for which the CTU is to be used. The request for a post-operative cold therapy unit (CTU) **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.