

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/18/2013
Date of Injury: 6/20/2012
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0006504

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder and wrist pain reportedly associated with an industrial injury of June 28, 2012.

Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; attorney representation; an MRI arthrogram of the shoulder of May 30, 2013, notable for mild subscapularis tendons and no evidence of labral rotator cuff tear; unspecified amounts of chiropractic manipulative therapy; and extensive periods of time off of work.

The applicant was on total temporary disability for large portions of the claim history but was later given work restrictions, which do not appear to be accommodated by the employer.

In a utilization review report of July 18, 2013, the claims administrator denied the request for chiropractic treatment, psych consult, MRI of the shoulder, and electrodiagnostic testing. The applicant's attorney subsequently appealed, on July 30, 2013.

In an April 8, 2013 consultation, the applicant is described as exhibiting full range of motion about the bilateral shoulders, with flexion and abduction to 180 degrees bilaterally. A positive Speed test is appreciated. The applicant reports multifocal complaints of pain including about the wrist, neck, back, shoulder, etc. The applicant's shoulder pain is scored at 4/10. Shoulder strength is 5/5, although the left wrist strength is scored at 4/5. The applicant is asked to remain off of work, on total temporary disability. It was stated that MRI imaging of the cervical spine and electrodiagnostic testing of the bilateral upper extremities should be obtained from the applicant's prior treating physician. A later note of June 4, 2013 is notable for comments that the applicant carries diagnoses of left wrist tenosynovitis, left shoulder tenosynovitis, neck pain, myalgias, myofascitis, anxiety, and depression. The applicant was again placed off of work as of that date.

Earlier notes of December 17, 2012, January 9, 2013, and February 4, 2013 are notable for comments that the applicant underwent manipulation on those dates.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Chiropractic treatment 2 times 4 to the cervical and lumbar spine is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, pg 153, 300, and the Official Disability Guidelines, (ODG), online version, Section on Low Back Treatment, which is not part of the MTUS. The Claims Administrator also cited the MTUS, Manual Therapy & Manipulation.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg 58-59 of 127, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Guidelines indicate that the cardinal criterion for continuation of manipulative therapy is evidence of successful return to work. In this case, the medical records provided reflect there is no evidence that the employee has returned to work. The employee has remained on total temporary disability for large portions of claim. In this case, the employee's failure to return to any form of work argues against continuation of manipulative therapy. It is also important to note that the employee has had prior unspecified amounts of manipulative therapy in 2012 and 2013 with no documentation as to the success of that therapy. **The request for chiropractic treatment 2 times 4 to the cervical and lumbar spine is not medically necessary and appropriate.**

2. A psychiatric consult is medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Psychotherapy Guidelines, which is not part of the MTUS, and ACOEM Guidelines, Chapter 15, pg 387, 389, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Stress Related Conditions Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 15) pg 398, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate that psychiatric consultations are recommended in those individuals with mental health symptoms that persist for greater than four to six weeks. On February 25, 2013, a progress note indicates the employee reports ongoing issues with anxiety depression, irritability and insomnia. In this case, the employee has had longstanding mental health issues, several years removed from the date of injury. Obtaining a psychiatry consultation is indicated and appropriate. **The request for a psychiatric consult is medically necessary and appropriate.**

3. MRI of the left shoulder is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, pgs 207, 210, and Official Disability Guidelines (ODG), MRI of the Shoulder, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines endorse MRI for preoperative evaluation of large full-thickness rotator cuff tears or partial thickness rotator cuff tears, in this case, however, the medical records reflect that there is no evidence that the employee is a candidate for surgery or would consider surgery were it offered. In fact, the employee's largely negative shoulder MRI of May 2013 and recent orthopedic consultation establishing normal well-preserved 5/5 shoulder strength and normal range of motion with flexion and abduction to 180 degrees about the bilateral shoulders suggests that the employee is not a surgical candidate. **The request for an MRI of the left shoulder is not medically necessary and appropriate.**

4. EMG/NCV is not medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines (2007), pgs. 63 and 303, which is not part of the MTUS. The Claims Administrator also cited the Official Disability Guidelines (ODG), EMG, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate that electrodiagnostic testing would help identify subtle or focal neurological function in the claimant with neck or arm symptoms or both lasting greater than three to four weeks. In this case, the employee's multifocal pain complaints, pertaining to the shoulder, wrist, neck, low back, etc., coupled with the employee's ongoing psychiatric issues, argues against the presence of any neurologic dysfunction, subtle or overt. **The request for EMG/NCV is not medically necessary and appropriate.**

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[REDACTED]

CM13-0006504