

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	9/14/2012
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007151

- 1) MAXIMUS Federal Services, Inc. has determined the request for **outpatient physical therapy (PT) two (2) times a week for four (4) weeks for the right shoulder** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/3/2013. 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 **outpatient physical therapy (PT) two (2) times a week for four (4) weeks for the right shoulder 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 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.

Expert Reviewer Case Summary:

The patient is a 52-year-old male who reported an injury on 09/04/2012 as the result of a slip and fall, causing injury to his right shoulder and ribs. The patient complains of right shoulder pain with radicular symptoms to his forearm. The Primary Treating Physician's Initial Report dated 05/29/2013 reported that the patient was utilizing a sling and immobilizer with benefit and had attended 8 visits of physical therapy with slight benefit. An unofficial report of an MRI of the right shoulder in 10/2012 revealed a stretched rotator tendon, which the patient was told was the result of normal wear and tear. An unofficial report of an x-ray of the right shoulder dated 05/13/2013 revealed a well-healed proximal humeral fracture, obvious type III downsloping acromion predisposing to impingement and mild to moderate acromioclavicular joint osteoarthritis. The patient was diagnosed with a right proximal humerus fracture and right shoulder impingement syndrome. A request for physical therapy 2 times a week for 4 weeks for the right shoulder was denied on 07/09/2013, citing that the request did not address what functional limitations the employee demonstrated that would preclude self management with a home exercise program. The DWC PR-2 dated 08/01/2013 stated that the patient reported 80% improvement since receiving a cortisone injection on 06/20/2013. The patient continued to complain of limitation to the right shoulder associated with weakness and a "catching" of the right shoulder. The PR-2 reported physical findings of tenderness to palpation of the right paracervical spine muscle and right trapezius muscle. The PR-2 further reported physical findings of tenderness to palpation of the anterior and lateral deltoids about the right shoulder. Passive circumduction was smoothly accomplished in the right shoulder with pain. Impingement testing was negative with Neer's test positive and a complaint of pain in the right shoulder at extremes of range of motion. Abduction was limited to 190 degrees with flexion limited to 150 degrees; there was weakness noted in the right shoulder as compared to the left shoulder and a positive supraspinatus test.

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
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for outpatient physical therapy (PT) two (2) times a week for four (4) weeks for the right shoulder :

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 MTUS, Chronic Pain Chapter Physical Medicine, pgs 98-99.

The Expert Reviewer based his decision on the Chronic Pain Medical Treatment Guidelines Physical Medicine and California MTUS, Chronic Pain Chapter, Physical Medicine, pgs 128-129.

Rationale for the Decision:

The California MTUS Guidelines recommend 8 to 10 visits of physical therapy over 4 weeks for this type of injury. The employee has been provided with 8 visits of physical therapy to date for the compensable injury of 09/04/2012. The request for 8 additional physical therapy visits exceeds the recommended guidelines. The clinical information submitted for review does not evidence physical findings that suggest a change in the employee's status to warrant exceeding the guidelines. Furthermore, the clinical information does not provide objective physical findings to suggest that the employee has achieved improvement in functional capabilities as a result of the 8 visits of physical therapy the employee has been provided to warrant the medical necessity of additional visits. **The request for outpatient physical therapy 2 times a week for 4 weeks for the right shoulder 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, 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.