

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	6/4/2013
Date of Injury:	3/29/2013
IMR Application Received:	6/14/2013
MAXIMUS Case Number:	CM13-0000698

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left shoulder arthroscopy acromioplasty, mumford procedure, and extensive debridement is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/14/2013 disputing the Utilization Review Denial dated 6/4/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/22/2013. 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 **left shoulder arthroscopy acromioplasty, mumford procedure, and extensive debridement 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 42-year-old who reported an injury on 03/29/2013. Primary treating physician's progress report dated 04/04/2013 states that the patient has moderately severe right shoulder pain. Physical findings included tenderness of the right acromioclavicular joint, tenderness of the right trapezius muscle and deltoid, and muscle spasms in the trapezius and deltoid muscles. The patient had a negative impingement test. It was noted that the patient was to continue physical therapy and an MRI was recommended. The patient received 3 additional physical therapy sessions. The clinical note dated 04/11/2013 indicated that the patient had no weakness in the left upper extremity and range of motion was considered to be within normal limits. The patient continued to experience pain that was exacerbated by repetitive motions. The clinical note dated 04/11/2013 indicated that the patient had developed a positive impingement sign. However, the clinical note dated 04/18/2013 provided an inconsistent result as the patient tested negative on the left side for an impingement sign. The patient received additional physical therapy. Range of motion of the left shoulder was described as limited in abduction to 80 degrees. An MRI was requested. The patient received acupuncture treatments. An MRI dated 05/06/2013 concluded that there was mild supraspinatus tendinosis, moderate acromioclavicular joint osteoarthritis, and mild labral fraying anterosuperiorly. The clinical note dated 05/10/2013 stated that the patient's pain continued to increase despite conservative treatments and the patient was given a 16 mg injection of Toradol to relieve pain. Initial orthopedic consultation dated 05/13/2013 stated that the patient had 8/10 pain that was exacerbated by movement. Physical findings included tenderness to palpation over the anterior subacromial space, restricted range of motion to 40 degrees in flexion, 60 degrees in abduction, 30 degrees in internal rotation, and 70 degrees in external rotation. It is noted that the patient had a positive impingement sign. It is noted that the patient was given a cortisone injection to the left shoulder. Primary treating physician's progress report dated 07/18/2013 indicated that the patient received a second steroid injection to the subacromial space.

Left shoulder range of motion was described as 140 degrees in flexion and 100 degrees in abduction. Left shoulder arthroscopic surgery was requested.

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 left shoulder arthroscopy acromioplasty, mumford procedure, and extensive debridement:

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 American College of Occupational and Environmental Medicine (ACOEM).

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg. 211, which is part of the MTUS.

Rationale for the Decision:

The MTUS/ACOEM Guidelines indicate that conservative care including cortisone injections can be carried out for at least 3 to 6 months before considering surgery. The medical records provided for review do not indicate that the employee has failed to respond to physical therapy and non-steroidal anti-inflammatory medications. The medical records show evidence that the employee has received a previous steroid injection; however, the effectiveness of the injection was not provided. **The request for left shoulder arthroscopy acromioplasty, mumford procedure, and extensive debridement 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.