

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 Continuous Passive Motion Unit Shoulder Rental **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Pain Pump **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/17/2013 disputing the Utilization Review Denial dated 6/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/17/2013. 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 Continuous Passive Motion Unit Shoulder Rental **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested Pain Pump **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 Internal 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 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 letter of appeal from [REDACTED], MD, dated June 13, 2013

“Please note that the patient was diagnosed with left shoulder rotator cuff tearing with bursitis, acromioclavicular joint symptoms and possible superior labrum, anterior and posterior, tear. In his most recent follow up evaluation on May 17, 2013, the patient complained of pain in the left shoulder, with pain radiating to the arm, elbow and fingers, He rated the severity of the pain as a 5/10 with noted tingling, numbness and weakness of the hand and fingers. The pain was worse with repetitive neck, bending and twisting, repetitive lifting and carrying, repetitive hand and arm movements, one-time lifting of items weighing greater than 1 pound and repetitive overhead reaching. The pain was alleviated by medications. The left shoulder was tender about the biceps tendon. The acromioclavicular joint was tender. The supraspinatus and impingement maneuvers elicited pain complaints. The lift-off maneuver and O'Brien's test were positive. AP and lateral views of the patient's left shoulder taken today show a type II acromion. There was little if any hypertrophy of the acromioclavicular joint. There was very mild arthrosis. He was advised to undergo shoulder surgery. He requires a left shoulder rotator cuff repair. He also requires subacromial decompression and excisional acromioclavicular joint arthroplasty. Based on what I see clinically, he probably has a SLAF tear which is going to require repair as well. Medications and transdermal creams were prescribed for symptomatic relief. In dispute, ~given my patient is contemplating surgery with his persistent state of functional disability resulting from the sustained industrial injury, it is evident that further management is indicated to address the various complaint~> that were brought about by his accident and most especially his scheduled surgery. After the surgical intervention, it is expected for the patient

to experience pain and weakness.”

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 6/17/2013
- Utilization Review Determination for Pain Pump provided by [REDACTED], dated 6/05/2013
- Utilization Review Determination for Continuous Passive Motion Unit for the shoulder provided by [REDACTED], dated 6/05/2013
- Medical Records from [REDACTED], MD dated 6/13/2013
- Official Disability Guidelines – Shoulder Section – Continuous Passive Motion (CPM) Unit – Current Version
- Official Disability Guidelines – Shoulder Section – Postoperative Pain Pump – Current Version

1) Regarding the request for the Continuous Passive Motion Unit Shoulder Rental:

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2009), Shoulder Section, Continuous Passive Motion (CPM), Current Version, which is a Medical Treatment Guideline (MTG) not in the California Medical Treatment Utilization Schedule (MTUS) and is the most recent version of the MTG. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer found the MTG used by the Claims Administrator relevant and appropriate for the employee’s clinical circumstance.

Rationale for the Decision:

The employee reported an injury to the left shoulder on 3/15/2013. The employee was diagnosed with left shoulder rotator cuff tearing with bursitis, acromioclavicular joint symptoms and possible superior labrum, anterior and posterior tear. According to a report from the treating provider dated 6/13/2013, the most recent evaluation on 5/17/2013 noted the employee described pain in the left shoulder radiating to the arm, elbow, and fingers. The pain severity was rated at 5/10 with noted tingling, numbness and weakness of the hand and fingers. Orthopedic tests were positive with repetitive lifting and carrying and overhead reaching. The pain was alleviated with medications and the employee was advised to undergo surgery. The request was for a continuous passive motion unit shoulder rental for rehabilitation post-surgery.

The Official Disability Guidelines (ODG), Shoulder Section, a MTG not in the

MTUS does not recommend CPM for rotator cuff tear shoulder surgery, only as an option for adhesive capsulitis. The diagnosis for the injury in this case is for rotator cuff tearing with bursitis, acromioclavicular joint symptoms and possible superior labrum, anterior and posterior tear. The requested Continuous Passive Motion Unit Shoulder Rental is not medically necessary and appropriate.

2) Regarding the request for the Pain Pump:

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

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2009), Shoulder Section, Post Operative Pain Pump, Current Version which is a Medical Treatment Guideline (MTG) not in the California Medical Treatment Utilization Schedule (MTUS) and is the most recent version of the MTG. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer found the MTG used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported an injury to the left shoulder on 3/15/2013. The employee was diagnosed with left shoulder rotator cuff tearing with bursitis, acromioclavicular joint symptoms and possible superior labrum, anterior and posterior tear. According to a report from the treating provider dated 6/13/2013, the most recent evaluation on 5/17/2013 noted the employee described pain in the left shoulder radiating to the arm, elbow, and fingers. The pain severity was rated at 5/10 with noted tingling, numbness and weakness of the hand and fingers. Orthopedic tests were positive with repetitive lifting and carrying and overhead reaching. The pain was alleviated with medications and the employee was advised to undergo surgery. The request was for a post-surgical pain pump.

The Official Disability Guidelines (ODG), Shoulder Section, Post-Operative Pain Pump, a MTG not in the MTUS, does not recommend the pain pump post-operatively. The ODG states that "there is insufficient evidence to conclude that direct infusion is as effective or more effective than conventional pre or post-operative pain control using oral or intra-muscular or intravenous measures" The requested post-operative pain pump 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, 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.