

Notice of Independent Medical Review Determination

Dated: 12/6/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/24/2013
Date of Injury: 10/13/2010
IMR Application Received: 8/14/2013
MAXIMUS Case Number: CM13-0011012

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right shoulder revision diagnostic/operative athroscopic debridement with acromioplasty resection of coracoacrominal ligament and bursa as indicated; possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-operative physical therapy, 12 visits is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request **for medical clearance is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request **for DVT prophylaxis is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **antibiotic pre-operative is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **assistant surgeon is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/14/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/20/2013. 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 **right shoulder revision diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa as indicated; possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-operative physical therapy, 12 visits is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **medical clearance is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **DVT prophylaxis is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **antibiotic pre-operative is medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **assistant surgeon 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:

This is a 51-year-old patient who sustained a right shoulder injury on 10/13/2010 that was reportedly related to repetitive work activities. The patient is status post a right shoulder arthroscopy with rotator cuff repair performed on 07/26/11. The patient's diagnosis was documented as right shoulder pain. The patient's conservative care to date was documented as a 9/16/2013 Kenalog injection to the right shoulder that provided no relief; in addition, the patient developed an adverse reaction of itchy skin and hot flashes lasting approximately three days following injection; physical therapy, 12 sessions, which worsened her symptoms; pain medications; anti-inflammatories; "multiple" injections; acupuncture; pain management.

The 11/6/2012 [REDACTED] Qualified Medical Evaluation report treatment recommendations were subacromial cortisone injection, diagnostic and therapeutic, shoulder specialist evaluation/treatment, MR Arthrogram right shoulder and possible EMG (electromyogram) and NCS (nerve conduction study). The 9/23/2013 office visit note referred to a 5/14/2013 MRI of the right shoulder that was interpreted as rotator cuff tendon as well as absence of biceps tendon and labral tearing. The right shoulder MRI arthrogram report was illegible.

The 9/23/2013 office note by [REDACTED] stated that the patient reported loss of motion, weakness, and discomfort of her right shoulder. The patient reported difficulties with her activities of daily living including difficulty lifting, difficulty driving, the inability to walk any significant distance and daily headaches. The exam findings revealed positive Neer and Hawkins impingement signs, positive arm drop, empty can testing and positive cross-arm. The patient demonstrated guarded range of motion and had difficulty reaching the back of her head. The patient demonstrated forward flexion and abduction at 100 degrees and internal rotation to the iliac crest. The plan was surgical intervention.

[REDACTED] requested a right shoulder revision diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa as indicated; possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis, post-operative physical therapy 12 sessions, medical clearance, DVT (deep vein thrombosis) prophylaxis and antibiotic pre-operative and an assistant surgeon. These requests were previously reviewed and non-certified by [REDACTED] on 7/23/2013 because the office visit note from [REDACTED] of 6/25/2013 did not establish the patient's current range of motion. [REDACTED] has not provided any new information with his appeal.

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 right shoulder revision diagnostic/operative athroscopic debridement with acrominoplasty resection of coracoacrominal ligament and bursa as indicated; possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), page 209 - 210,

which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), page 209 - 210, which is part of the MTUS, as well as the Official Disability Guidelines, which is not part of the MTUS.

Rationale for the Decision:

The medical records provided were reviewed alongside the appropriate guidelines. According to the ACOEM Practice Guidelines, "Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. Rotator cuff tears are frequently partial-thickness or smaller full thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months."

The requested surgical intervention to include diagnostic and operative arthroscopy, acromioplasty, possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis is medically necessary based on review of this medical record. The 09/23/13 letter of [REDACTED] clearly describes ongoing subjective complaints, positive physical findings, failure of appropriate conservative care, and a description of abnormal diagnostic testing. The guidelines were reviewed, and the request for surgical intervention falls within these guidelines. **The request for right shoulder revision diagnostic/operative arthroscopic debridement with acromioplasty resection of coracoacromial ligament and bursa as indicated; possible distal clavicle resection with possible rotator cuff repair and biceps tenodesis is medically necessary and appropriate.**

2) Regarding the request for post-operative physical therapy, 12 visits:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, shoulder chapter, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, shoulder section, which is part of the MTUS

Rationale for the Decision:

According to Post-Surgical Treatment Guidelines, postsurgical arthroscopic Rotator cuff syndrome/Impingement syndrome therapy is limited to 24 visits over 14 weeks, while postsurgical open Rotator cuff syndrome/Impingement syndrome therapy is limited to 30 visits over 14 weeks. The medical review of the provided records found that the requested 12 sessions of physical therapy in the postoperative time frame are medically necessary. Since the decompression and debridement surgery was appropriate, then 12 visits of therapy fit within guidelines. **The request for post-operative physical therapy, 12 visits is medically necessary and appropriate.**

3) Regarding the request for medical clearance:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

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, Treatment in Worker's Comp 18th edition, 2013 Updates, Chapter: Low Back, which is not part of the MTUS.

Rationale for the Decision:

The requested medical clearance at this time is not medically necessary based on review of the medical record. The employee is a 51-year-old woman, and there is no description in the medical record of any acute or chronic medical issues. Medical clearance is not required for shoulder surgeries. The guidelines were reviewed in terms of need for medical evaluation and specific medical clearance prior to surgery. There is no documentation in the medical record of an acute or chronic medical condition that might need evaluation. **The request for medical clearance is not medically necessary or appropriate.**

4) Regarding the request for DVT prophylaxis:

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 Official Disability Guidelines (ODG), Shoulder Chapter, which is 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 (ODG), Shoulder Chapter, which is not part of the MTUS.

Rationale for the Decision:

According to the Official Disability Guidelines, "The administration of DVT prophylaxis is not generally recommended in shoulder arthroscopy procedures. The prevalence of DVT after reconstructive shoulder arthroplasty was 13%, compared to 27% after knee arthroplasty." DVT prophylaxis is usually only used in patients with upper extremity surgery who have a proven previous DVT issue. That is not documented in this record. **The request for DVT prophylaxis is not medically necessary or appropriate.**

5) Regarding the request for antibiotic pre-operative:

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 Official Disability Guidelines (ODG), Shoulder Chapter, which is 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 the Journal of the American Academy of Orthopaedic Surgeons: Prophylactic Antibiotics in Orthopaedic Surgery, which is not part of the MTUS.

Rationale for the Decision:

According to the Journal of the American Academy of Orthopaedic Surgeons, "The use of prophylactic antibiotics in orthopaedic surgery is effective in reducing surgical site infections in hip and knee arthroplasty, spine surgery, and open reduction and internal fixation of fractures. To maximize the beneficial effect of prophylactic antibiotics while minimizing adverse effects, the correct antimicrobial agent must be selected, the drug must be administered just before incision, and the duration of administration should not exceed 24 hours." The guidelines indicate that usually antibiotic prophylaxis is used for outpatient arthroscopic shoulder surgery, so that would be appropriate. **The request for antibiotic pre-operative is medically necessary and appropriate.**

6) Regarding the request for assistant surgeon:

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 The Milliman Care Guidelines, 12th Edition, Assistant Surgeons chapter which is 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 The Milliman Care Guidelines, 12th Edition, Assistant Surgeons chapter which is not part of the MTUS.

Rationale for the Decision:

The medical records provided were reviewed alongside the appropriate guidelines. According to the Milliman Care Guidelines, "for Arthroscopy, shoulder surgical repair of SLAP lesion, Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with or without coracoacromial release." The records show that this is going to be an arthroscopic procedure. Milliman Guidelines indicate that there is no medical necessity for a surgical assistant for an arthroscopic shoulder procedure. **The request for an assistant surgeon is not medically necessary or 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.