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**Notice of Independent Medical Review Determination**

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

8/2/2013

6/1/2012

8/14/2013

CM13-0011081

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one surgical consult for arthroscopic right shoulder surgery with distal clavical excision and possible rotator cuff repair between 06/18/2013 & 10/01/2013** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one pre-operative medical clearance between 06/18/2013 & 10/11/2013** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one CPM device for 45 days** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **one surgi-stim unit for 90 days** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **unknown supplies for orthostim 4 unit** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **twelve post operative rehabilitation sessions between 06/18/2013 & 11/01/2013** is not medically necessary and appropriate.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **one coolcare cold therapy unit between 06/18/2013 & 10/01/2013** 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 8/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/19/2013. 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 **one surgical consult for arthroscopic right shoulder surgery with distal clavical excision and possible rotator cuff repair between 06/18/2013 & 10/01/2013** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one pre-operative medical clearance between 06/18/2013 & 10/11/2013** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one CPM device for 45 days** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **one surgi-stim unit for 90 days** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **unknown supplies for orthostim 4 unit** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **twelve post operative rehabilitation sessions between 06/18/2013 & 11/01/2013** is not medically necessary and appropriate.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **one coolcare cold therapy unit between 06/18/2013 & 10/01/2013** 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 58 year old female claimant who sustained a right shoulder injury on 6/1/2012 when she stepped into a hole and fell. The claimant's diagnosis was documented as rotator cuff syndrome/impingement syndrome. The claimant's conservative care to date was documented as 6 sessions of acupuncture with no reported improvement, 9 sessions of physical therapy with reported improvement, a corticosteroid injection which resulted in an allergic reaction, a home exercise program, right knee brace, Thermophore heating pad, Norco and Fexmid. The 3/21/2013 sonogram of the right shoulder revealed no focal abnormalities.

The 6/18/2013 office visit note referred to a 9/11/2012 MRI right shoulder which was interpreted as moderate acromioclavicular joint degenerative disease, tendinosis of supraspinatus, infraspinatus, and subscapularis tendons, but no report was provided. The 8/9/2013 [REDACTED] office visit note stated that the claimant presented with right shoulder pain, sleep disturbances that increased with lifting, pushing, pulling and reaching. She had a positive impingement sign and tenderness to palpation over the periscapular musculature, subacromial region extending over anterior capsule and acromioclavicular joint. The claimant had neuro weakness, slight breakaway weakness with arm drop test. She had decreased range of motion abduction at 155 degrees; forward flexion 160 degrees; extension 40 degrees; adduction 40 degrees; external rotation 80 degrees; internal rotation 60 degrees. There was severe tenderness to palpation at supraspinatus; greater tuberosity tenderness; subacromial crepitus. The claimant demonstrated a positive acromioclavicular joint test; positive impingement I test; positive impingement II test; positive impingement III test. The plan was surgical intervention.

The request is for surgical consult for arthroscopic right shoulder surgery with distal clavicle excision and possible rotator cuff repair between 06/18/2013 & 10/01/2013; pre-operative medical clearance between 06/18/2013 & 10/11/2013; CPM device for 45 days, Surgi-Stim unit for 90 days; supplies for Orthostim 4 unit; 12 post operative rehabilitation sessions between 06/18/2013 & 11/01/2013; Coolcare Cold Therapy unit between 06/18/2013 & 10/01/2013.

### **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 Provider
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for one surgical consult for arthroscopic right shoulder surgery with distal clavical excision and possible rotator cuff repair between 06/18/2013 & 10/01/2013 :**

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

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 9 (Shoulder Complaints) (2004), pg. 210- 211, which is a part of the MTUS and the Official Disability Guidelines, (ODG), Shoulder (Acute & Chronic), which is not a part of the MTUS.

The Expert Reviewer based his/her decision on Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9), Surgical Considerations, pgs. 209-211, which is part of the MTUS, and the Official Disability Guidelines, (ODG), Treatment in Worker's Comp 18<sup>th</sup> edition, 2013 Updates, Chapter: Shoulder - Indications for Surgery, which is not part of the MTUS.

Rationale for the Decision:

A review of the records indicated that after nine sessions of physical therapy there has been improvement of subjective complaints in this employee. There is an MRI that did not demonstrate any full thickness or high grade partial thickness tear of the rotator cuff on 09/11/12 and showed no focal abnormalities. There has been no recent injections, and because of this, surgery is not warranted. Other treatment or considerations should be undertaken for a longer period of time prior to surgery. **The request for one surgical consult for arthroscopic right shoulder surgery with distal clavical excision and possible rotator cuff repair between 06/18/2013 & 10/01/2013 is not medically necessary and appropriate.**

**2) Regarding the request for one pre-operative medical clearance between 06/18/2013 & 10/11/2013 :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**3) Regarding the request for one CPM device for 45 days :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**4) Regarding the request for one surgi-stim unit for 90 days :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**5) Regarding the request for unknown supplies for orthostim 4 unit :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**6) Regarding the request for twelve post operative rehabilitation sessions between 06/18/2013 & 11/01/2013 :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**7) Regarding the request for one CoolCare cold therapy unit between 06/18/2013 & 10/01/2013 :**

Since the primary procedure is not medically necessary, **none of the associated services are medically necessary.**

**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, 18<sup>th</sup> 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.