
Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/6/2013
Date of Injury: 10/6/2009
IMR Application Received: 8/15/2013
MAXIMUS Case Number: CM13-0011355

- 1) MAXIMUS Federal Services, Inc. has determined the request for **surgery: open surgical repair of rotator cuff right shoulder with use of assistant surgeon is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op physical therapy 3 times a week for 4 weeks for the right shoulder is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **general surgeon consult for left inguinal hernia is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **treatment of lower back and MRI lumbar spine is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 8/6/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/23/2013. 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 **surgery: open surgical repair of rotator cuff right shoulder with use of assistant surgeon is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op PT 3 times 4 right shoulder is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **general surgeon consult for left inguinal hernia is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **treatment of lower back and MRI lumbar spine 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 Texas. 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.

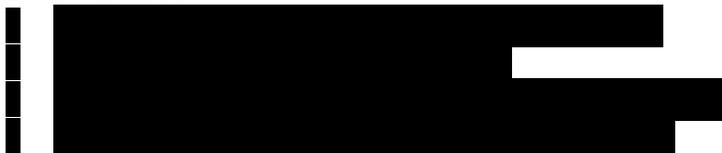
Expert Reviewer Case Summary:

The patient is a 56-year-old male who reported an injury on 10/06/2009. The documentation submitted for review indicates that the patient was on a boat when he slipped and twisted his knee and tried to grab something with his right arm. Physical examination of the patient as of 06/26/2013 notes that the patient has complaints of bilateral shoulder pain, weakness to the bilateral shoulders with popping and clicking, as well as limited range of motion. Examination of the right shoulder reveals tenderness of the AC joint with mild arc sign and a negative Neer's sign; however, positive Hawkins sign. Subluxation test was noted to be normal and range of motion of the right shoulder was decreased with abduction of 110 degrees, adduction 30 degrees, flexion 90 degrees, extension 20 degrees, internal rotation and external rotation 30 degrees, and 4/5 strength testing throughout all muscle groups of the right shoulder. Furthermore, notes indicate that the patient has undergone conservative treatment in the form of physical therapy, medication management, and injection of the subacromial space. Also, clinical notes indicate that the patient had undergone an MRI of the right shoulder, which revealed decreased coracohumeral distance, possibly predisposing the patient to

subscapularis tendon impingement and evidence was noted of the AC joint osteoarthritis, as well as a possible rim rent tear of the supraspinatus and anterior aspect of the infraspinatus.

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:



1) Regarding the request for surgery: open surgical repair of rotator cuff right shoulder with use of 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), pg. 209, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 209-211, which is part of MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate the recommendation for surgical consultation for those patients with red-flag conditions, as well as activity limitation for more than 4 months plus existence of a surgical lesion, and for those patients with failure to increase range of motion and strength of the musculature around the shoulder, even after exercise programs, plus existence of a surgical lesions; and further recommendation is made for clear clinical imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. A review of the records submitted indicates that the employee has sufficient orthopedic findings on physical examination to support the recommendation for surgery. The imaging studies of the employee's right shoulder demonstrate acromioclavicular joint arthrosis and possible rim rent tears of the supraspinatus and anterior aspect of the infraspinatus, further supporting the recommendation for surgery. However, the imaging studies of the employee's shoulder were not submitted for review. Additionally, the 2011 Physicians as Assistants at Surgery, page 32, indicates support for an assistant surgeon is almost always needed for repairs of both acute and chronic ruptured musculotendinous cuffs. However, the current request fails to be supported due to a lack of the official imaging studies. **The request for surgery with open surgical repair of the rotator cuff of the right shoulder with the use of an assistant surgeon is not medically necessary and appropriate.**

2) Regarding the request for post-op physical therapy 3 times a week for 4 weeks for the right shoulder:

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

3) Regarding the request for general surgeon consult for left inguinal hernia:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on the Cornerstones of Disability Prevention and Management (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 5), pages 89-92, Referrals, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate the recommendation for referrals as a cornerstone of disability prevention and management. Furthermore, surgical consultation is generally indicated for patients who have activity limitation of more than 1 month or failure to progress in exercise programs and increasing range of motion and strength of the musculature. Also, referral may be indicated generally for patients with clear clinical and imaging evidence of a lesion shown to benefit in both the short and long term from surgical repair. A review of the documentation submitted, while indicating a request for surgical consultation with a general surgeon for the employee's left inguinal hernia, fails to indicate objective clinical findings regarding the suspected hernia or any diagnostic studies performed for further corroboration of findings. **The request for a general surgeon consult for left inguinal hernia is not medically necessary and appropriate.**

4) Regarding the request for treatment of lower back and MRI lumbar spine:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not provide any evidence-based guidelines for its decision.

The Expert Reviewer based his/her decision on the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), pages 303-305, Special Studies and Diagnostic and Treatment Considerations, which is a part of the MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines indicate that unequivocal objective findings which identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging studies in patients who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. A review of the records currently indicates a recommendation for treatment of the employee's lower extremity radiculopathy and for an MRI of the lumbar spine secondary to pain and radiculopathy. Based on the medical records submitted for review, the employee has a long, ongoing history of low back pain and radicular symptoms for which the patient is undergoing treatment. Evaluation of the employee on 06/26/13 noted on physical exam that the employee had positive findings for spasms in the lumbar region and tenderness over the paraspinal muscles and spinous processes. Straight leg raise is noted to be positive at 70 degrees bilaterally, with range of motion of the lumbar spine indicated as decreased and painful with forward flexion within 18 inches from the floor, and extension, lateral bending bilaterally, and axial rotation bilaterally at 10 degrees. Motor strength of the employee was rated as 4/5 in all muscle groups of the lumbar spine. However, there is no clear indication of any progressive neurological deficits noted for the employee, pain in a myotomal distribution, or paresthesia in a dermatomal distribution. There was no indication of blunted reflexes or other significant neuropathology to warrant treatment or MRI of the lumbar spine. **The request for treatment of lower back and MRI of the lumbar spine 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.