MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 12/16/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/24/2013
Date of Injury:	8/27/2012
IMR Application Received:	8/15/2013
MAXIMUS Case Number:	CM13-0011855

1) MAXIMUS Federal Services, Inc. has determined the request for **right shoulder arthroscopy possible RCR is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Assistant Surgeon is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **Post Op Physical Therapy x 12 is not medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Continuous Passive Motion (CPM) x 21 days rental 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 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/26/2013. 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 arthroscopy possible RCR** is not **medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for **Assistant Surgeon** is not **medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for **Post Op Physical Therapy x 12** is not **medically necessary and appropriate.**

4) MAXIMUS Federal Services, Inc. has determined the request for **Continuous Passive Motion (CPM) x 21 days rental** 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 Hand 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 57-year-old female who reported injury on 08/27/2012. The mechanism of injury was stated to be the patient was working with a sorting machine for onions and picked up a big rock and threw it out. The patient was noted to have a positive impingement sign, normal RC strength, but painful, and pain at the extremes of range of motion and range of motion was noted to be normal on the right side. The patient was noted to have flexion of 160 degrees. The patient was noted to have diagnoses of right shoulder impingement and AC joint arthropathy. The treatment plan was noted to include right shoulder arthroscopy with possible RCR, assistant surgeon, postoperative physical therapy x 12 visits, and continuous passive motion.

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:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

1) **Regarding the request for right shoulder arthroscopy possible RCR:**

   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), Chapter 9) pages 210-211, which is part of the MTUS, and the Official Disability Guidelines (ODG), Shoulder section, 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), Shoulder Complaints, pages 210-211, which is part of the MTUS.

   Rationale for the Decision:
   Per the MTUS/ACOEM Guidelines, a rotator cuff tear repair is indicated for significant tears that impair activities caused by weakness of arm elevation and rotation, particularly in acute, young workers. Rotator cuff tears are frequently partial-thickness or small fuller 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 3 months. MTUS/ACOEM Guidelines additionally recommend surgery for an impingement syndrome, to include conservative care, including cortisone injections for 3 to 6 months before considering surgery. CA MTUS/ACOEM Guidelines state arthroscopic decompression is not indicated for employees with mild symptoms or those who have no activity limitations. The clinical documentation submitted for review indicated the employee had approximately 1 month of conservative care, indicated the employee had pain with extremes of range of motion, and indicated the employee had a positive impingement sign and temporary relief of pain with an anesthetic injection; however, failed to provide the employee had documentation of exhaustion of adequate conservative care. **The request for right shoulder arthroscopy possible RCR is not medically necessary and appropriate.**

2) **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 American Association of Orthopedic Surgeons, position statement reimbursement of the First Assistant at Surgery in Orthopedics, 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 Physician's 2011 Physicians as Assistants at Surgery, which is not part of the MTUS

Rationale for the Decision:
Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3) **Regarding the request for Post Op Physical Therapy x 12:**

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 Post Surgical Treatment Guidelines, page 27, which is part of the MTUS

The Expert Reviewer based his/her decision on the Post Surgical Treatment Guidelines, General Guidelines, page 10, and Shoulder pages 26-27, which is part of the MTUS

Rationale for the Decision:
Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4) **Regarding the request for Continuous Passive Motion (CPM) x 21 days rental:**

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), Continuous Passive Motion (CPM), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder Chapter, Continuous Passive Motion (CPM), which is not part of the MTUS.

Rationale for the Decision:
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, 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.