
Notice of Independent Medical Review Determination

Dated: 12/16/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/26/2013
Date of Injury: 8/1/2011
IMR Application Received: 8/22/2013
MAXIMUS Case Number: CM13-0014701

- 1) MAXIMUS Federal Services, Inc. has determined the request for a **right shoulder arthroscopy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **repair of rotator cuff with labral debridement is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **possible biceps tenodesis is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **post-operative PT 3 x 4 weeks is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a **cold therapy unit x 7 days post-operatively is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for an **abduction pillow sling is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/22/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/7/2013. 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 a **right shoulder arthroscopy medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for a **repair of rotator cuff with labral debridement medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a **possible biceps tenodesis medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **post-operative PT 3 x 4 weeks medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for a **cold therapy unit x 7 days post-operatively medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for an **abduction pillow sling 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, has a subspecialty in Shoulder and Elbow 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 48-year-old male with a reported injury on 08/01/2011. The patient and a co-worker were reportedly pushing a large heavy roll of synthetic grass further into the back of a truck when he experienced a sudden onset of neck, right shoulder and midback pain. The patient initially underwent a Mumford procedure with acromioplasty followed by postoperative therapy, which did not significantly improve his symptoms. A repeat MR arthrogram of the right shoulder performed on 04/01/2013 revealed a moderate-sized high grade partial undersurface tear of the mid and posterior fibers of the supraspinatus with retraction and atrophy as well as labral tearing extending posteriorly from the superior to the inferior labrum. The patient then underwent a second right shoulder surgery on 05/03/2013, which consisted of release of the biceps tendon, partial labrectomy superiorly and posteriorly, biceps tenodesis with internal fixation, rotator cuff repair, revision of subacromial decompression with resection of

adhesions/scar tissue and revision of Mumford. The patient subsequently followed up with Dr. [REDACTED] on 09/13/2013 due to continued right shoulder pain that was reportedly worse than pre-op with limited range of motion and had completed approximately 15 visits of physical therapy. Examination revealed tenderness to the right shoulder and decreased right shoulder range of motion. A repeat MR arthrogram of the shoulder was recommended. Followup examination on 09/30/2013 revealed that the patient had a repeat MRI of the shoulder pending. Diagnoses included severe impingement syndrome of the right shoulder status post right shoulder arthroscopy on 09/26/2012 and right shoulder arthroscopy on 05/03/2013.

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:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for right shoulder arthroscopy :

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 ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), 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) pages 209-210, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months, plus existence of a surgical lesion and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The medical records provided for review indicated that the employee was pending a new MRI of the right shoulder. The most recent imaging report submitted for review was a right shoulder MR arthrogram dated 04/01/2013, which was prior to the most recent surgical intervention of 05/03/2013. There is a lack of recent imaging revealing a surgical lesion supportive of surgical intervention. **The request for a right shoulder arthroscopy is not medically necessary and appropriate.**

2) Regarding the request for repair of rotator cuff with labral debridement :

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

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), 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) pages 209-211, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months, plus existence of a surgical lesion and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The medical records provided for review indicated that the employee was pending a new MRI of the right shoulder. The most recent imaging report submitted for review was a right shoulder MR arthrogram dated 04/01/2013, which was prior to the most recent surgical intervention of 05/03/2013. There is a lack of recent imaging revealing a surgical lesion supportive of surgical intervention. **The request for a repair of rotator cuff with labral debridement is not medically necessary or appropriate.**

3) Regarding the request for possible biceps tenodesis :

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 ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), 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) pages 209-210, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months, plus existence of a surgical lesion and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. The medical records provided for review indicated that the employee was pending a new MRI of the right shoulder. The most recent imaging report submitted for review was a right shoulder MR arthrogram dated 04/01/2013, which was prior to the most recent surgical intervention of 05/03/2013. There is a lack of recent imaging revealing a surgical lesion supportive of surgical intervention. **The request for a possible biceps tenodesis is not medically necessary and appropriate.**

4) Regarding the request for post-operative PT 3 x 4 weeks :

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 ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, pages 10 and 27, which is part of the MTUS.

Rationale for the Decision:

The California MTUS Postsurgical Treatment Guidelines state, "Initial course of therapy" means 1/2 of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical medicine treatment recommendations set forth in subdivision (d)(1) of this section. The California MTUS Postsurgical Treatment Guidelines would recommend 24 visits over 14 weeks. However, as the surgical intervention has not been certified, the necessity of the postoperative physical therapy has not been met. **The request for PT 3 x 4 weeks is not medically necessary and appropriate.**

5) Regarding the request for cold therapy unit x 7 days post-operatively :

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 ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), 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) pages 201-205, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines state that home, local applications of cold during the first few days of acute complaints; thereafter, heat application. The Official Disability Guidelines state that continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. As the requested surgical intervention has not been certified, the necessity of the postoperative cold therapy unit times 7 days has not been met. **The request for a cold therapy unit x 7 days post-operatively is not medically necessary and appropriate.**

6) Regarding the request for a abduction pillow sling :

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 ACOEM Practice Guidelines, Shoulder Complaints Section, which is part of the MTUS and the Official Disability Guidelines (ODG), 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) pages 212-214, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

Rationale for the Decision:

The California MTUS Guidelines recommend the brief use of a sling for severe shoulder pain (1 to 2 days) with pendulum exercises to prevent stiffness in cases of rotator cuff conditions, and prolonged use of a sling only for symptom control is not supported. The Official Disability Guidelines (ODG) state that a postoperative abduction pillow sling is recommended as an option following an open repair of large and massive rotator cuff tears. As the requested surgical intervention has not been certified, the necessity of the requested abduction pillow sling has not been met. Also, as noted in the medical records submitted for review, the employee had utilized a post abduction pillow sling with the previous surgery, and it is not clear whether the employee still has the sling from the prior therapy. **The request for an abduction pillow sling 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

/jr

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.