

Independent Medical Review Final Determination Letter

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[REDACTED]

Dated: 12/20/2013

IMR Case Number:	CM13-0014800	Date of Injury:	08/17/2009
Claims Number:	[REDACTED]	UR Denial Date:	08/01/2013
Priority:	STANDARD	Application Received:	08/22/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
1. RIGHT SHOULDER ARTHROSCOPY WITH ROTATOR CUFF REPAIR AND SUBACROMIAL DECOMPRESSION 2. POST-OP PT 3X8 WEEKS			

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH

Medical Director

cc: Department of Industrial Relations, [REDACTED]
[REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 Louisiana and 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

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]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is an 83-year-old female, who reported an injury on 08/18/2009 secondary to a fall. Due to persistent left shoulder pain, the patient underwent a shoulder post arthrogram performed on 11/02/2009, which revealed a full-thickness tear of the supraspinatus tendon. The patient underwent surgical intervention and manipulation under anesthesia. The patient received physical therapy and participated in a home exercise program for the right shoulder. The patient does have continued shoulder pain. Physical findings included tenderness to the lateral aspect of the shoulder, decreased active range of motion, 120 degrees in flexion with pain. The patient's diagnoses included shoulder strain and rotator cuff tear of the right shoulder. Treatment planning included surgical intervention.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Right shoulder arthroscopy with rotator cuff repair and subacromial decompression is medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS, ACOEM chapter 9, 2nd Edition, page 210-211, which is part of the MTUS, and the Official Disability Guidelines (ODG), shoulder, which is not part of the MTUS. The Claims Administrator also cited the OKU #9 update, page 297, which is not part of the MTUS

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg 211-212, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The MTUS/ACOEM Guidelines indicate, “Rotator cuff repair is indicated for significant tears that impair activities of daily living by causing weakness of arm elevation or rotation, particularly 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 3 months.” The medical records provided for review indicate the employee had persistent pain complaints and limited range of motion that has been non-responsive to extensive physical therapy and medications. The medical records also indicate that the employee has failed to respond to extensive conservative therapy lasting longer than 3 months. **The request for right shoulder arthroscopy with rotator cuff repair and subacromial decompression is medically necessary and appropriate.**

2. Postoperative physical therapy three (3) times a week for eight (8) weeks is not medically necessary and appropriate.

The Claims Administrator based its decision on the California MTUS Postoperative Guide, page 27.

The Physician Reviewer based his/her decision on the Postsurgical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer’s decision rationale:

The Postsurgical Treatment Guidelines recommend 24 physical therapy visits over 14 weeks in the postsurgical care of rotator cuff syndrome/impingement syndrome. The guidelines also recommend an initial course of treatment to equal half of the recommended number of physical therapy treatments considered to be a general course of physical therapy. This would amount to 12 physical therapy visits. The medical records provided for review indicate the employee has received 70 physical therapy sessions over the course of the injury. The request exceeds guideline recommendations. **The request for postoperative physical therapy three (3) times a week for eight (8) weeks is not medically necessary and appropriate.**

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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.

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CM13-0014800