

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/25/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/26/2013
Date of Injury:	6/16/2009
IMR Application Received:	7/5/2013
MAXIMUS Case Number:	CM13-0001049

- 1) MAXIMUS Federal Services, Inc. has determined the request for right shoulder arthroscopy versus mini open with debridement acromioclavicular joint resection and subacromial **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 pre-op clearance to include CXR, EKG, CBC with Diff, CMP UA **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for cold unit (purchase) **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for twelve sessions of post-op physical therapy **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/5/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/27/2013. 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 versus mini open with debridement acromioclavicular joint resection and subacromial 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 pre-op clearance to include CXR, EKG, CBC with Diff, CMP UA **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for cold unit (purchase) **is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for twelve sessions of post-op physical therapy **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:

The patient is a female who reported a work-related injury to her right shoulder as a result of a fall on 06/16/2009. The clinical notes do not evidence the patient's date of birth. The clinical note dated 05/07/2013 reports the patient was seen for follow-up under the care of Dr. [REDACTED]. The provider documents the patient has a right shoulder acromioclavicular joint arthropathy and rotator cuff bursitis. The patient was last seen in clinic 2 to 3 weeks ago at which time the patient was provided with treatment options which included conservative treatment versus surgical interventions to the right shoulder. The provider documented the patient continues to present with painful right shoulder pointing to the top of her right shoulder which interferes with her sleep, as well as her activities of daily living. The patient reported the pain radiates down into her right upper extremity as well. Physical exam of the patient reveals the patient was in no acute distress; however, she was very teary-eyed and reported mostly due to her shoulder pain. The provider documented the patient had limited range of motion due to her painful shoulder; however, she had exquisite grade 2+ tenderness over the acromioclavicular joint and anterior margin of the acromion. Acromioclavicular joint

compression test is positive. Rotator cuff provocative tests were not performed due to the patient's pain sensitivity. The provider documented the patient would require cervical spine clearance as she is status post surgical interventions as of 01/2013. The provider requested authorization for right shoulder arthroscopy versus mini open procedure with debridement, acromioclavicular joint resection, and subacromial decompression, preoperative history and physical exam, 2 months of postoperative therapy, and a cold therapy unit

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 right shoulder arthroscopy versus mini open with debridement acromioclavicular joint resection and subacromial:

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 College of Occupational and Environmental Medicine, 2nd Edition, Shoulder Complaints, Surgical Considerations and Postsurgical Treatment Guidelines, which are part of the MTUS, and the Official Disability Guidelines (ODG), Surgery for impingement syndrome and Indications for surgery, Acromioplasty, which are 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), Surgical Considerations and Impingement Syndrome, page 211, which is part of the MTUS

Rationale for the Decision:

The current request previously received an adverse determination due to a lack of submitted documentation evidencing exhaustion of conservative care. Furthermore, specifically for this review, there were no imaging studies of the employee's right shoulder submitted for review, to support the requested operative procedure. As ACOEM indicates, "Referral for surgical consultation may be indicated for patients who have clear clinical imaging evidence of a lesion that has been shown to benefit in both the short-term and long-term from surgical repair." **The request for pre-op clearance to include CXR, EKG, CBC with Diff, CMP UA, is not medically necessary and appropriate.**

2) Regarding the request for assistant surgeon:

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

3) Regarding the request for pre-op clearance to include CXR, EKG, CBC with Diff, CMP UA:

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

4) Regarding the request for cold unit (purchase):

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

5) Regarding the request for twelve sessions of post-op physical therapy:

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

/sce

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.