
Notice of Independent Medical Review Determination

Dated: 9/6/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/8/2013
Date of Injury: 9/29/2010
IMR Application Received: 7/16/2013
MAXIMUS Case Number: CM13-0001666

- 1) MAXIMUS Federal Services, Inc. has determined the request for a left shoulder arthroscopic capsulotomy **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for post-operative physical therapy (3 times a week for 4 weeks) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a continuous passive motion (CPM) rental for 4 weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a thermal compression therapy rental for 21 days **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/16/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/19/2013. 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 left shoulder arthroscopic capsulotomy **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for post-operative physical therapy (3 times a week for 4 weeks) **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for a continuous passive motion (CPM) rental for 4 weeks **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a thermal compression therapy rental for 21 days **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, has a subspecialty in Sport Medicine 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 5, 2013.

According to the medical records, the patient is a 44-year-old male who sustained an industrial injury on 9/20/10. He is a social worker. He fell down a complete stairway in a barn, in attempt to avoid three dogs. He was in a MVA on 12/21/10 resulting in injuries to his axial skeleton. The patient is status post left shoulder extensive arthroscopic debridement, arthroscopic decompression of the subacromial space, synovectomy, capsular contracture release, and manipulation under anesthesia with injection on 6/17/11, and right shoulder subacromial decompression, extensive debridement, synovectomy, and manipulation under anesthesia with injection on 5/10/13.

An electrodiagnostic report of the bilateral upper and lower extremities with associated cervical and lumbar paraspinal musculature revealed evidence of probable mild right L4, L5, and possibly left L5 radiculopathy with fibrillation potentials in the right L4 and L5 paraspinal areas and slight increased inscrtional activity of the left L5 level. The upper extremity examination showed mild chronic neurogenic changes in the supraspinatus and infraspinatus muscles, left slightly worse than right.

A 12/5/12 QME by Dr. [REDACTED] reviews a lumbar MRI dated 11/27/12, demonstrating L4-5 disc desiccation and a 5 mm circumferential disc osteophyte complex, with mild facet and ligamentum flavum hypertrophy, as well as mild dural compression and bilateral lateral recess narrowing encroaching on the L5 nerve roots. At L5-S1 there is a 3 mm central disc protrusion with mild bilateral facet and ligamentum flavum hypertrophy. There was mild dural compression without lateral recess stenosis. There was mild right neural foraminal stenosis. A cervical MRI scan dated 11/26/12 was reviewed demonstrating a 2 mm central disc protrusion at C3-4 with mild dural compression. At C4-5 there was mild bilateral facet hypertrophy. There was no dural compression or neural foraminal stenosis. At C5-6 there is a right-sided posterior lateral disc osteophyte complex measuring 3 mm. Mild bilateral facet hypertrophy was noted. There was mild dural compression with mild indentation of the spinal cord on the right anteriorly. There was moderate right and mild left neural foraminal stenosis. At C6-7, there was mild bilateral facet and ligamentum flavum hypertrophy with mild dural compression without indentation of the spinal cord. Dr. [REDACTED] recommends that the patient should be considered for right shoulder arthroscopic surgery to include subacromial decompression and rotator cuff repair. A manipulation under anesthesia should be considered for both shoulders.

According to a 6/10/13 examination by Dr. [REDACTED] the patient reports he has continued in therapy. He uses the CPM, but finds that he is not able to use it for as long as instructed due to discomfort in a seated position. He has continued in therapy, but believes he would be better suited to perform therapy at home. Examination of the left shoulder reveals 60 degrees of flexion and 50 degrees of abduction. The patient is diagnosed of bilateral frozen shoulders and status post right shoulder manipulation under anesthesia with arthroscopic debridement. The patient has not returned to work since the time of the last examination, and is temporarily totally disabled until 7/22/13.

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 for Independent Medical Review
- Utilization Review Determination by [REDACTED] (dated 7/8/13)
- Physician Peer Review by [REDACTED] (dated 7/5/13)
- Medical Records by [REDACTED], M.D. (dated 6/4/12 to 7/3/13)
- QME Supplemental Report by [REDACTED], M.D. (dated 12/5/12)
- Operative Report by [REDACTED] (dated 5/10/13)
- EMG/NCS Report by [REDACTED], M.D. (dated 11/27/12)
- Multidimensional Task Ability Profile Report Card by [REDACTED] (dated 5/15/13)
- MRI Report (dated 11/28/12)
- Official Disability Guidelines (ODG) – Shoulder Chapter, Surgery for Adhesive Capsulitis section

1) Regarding the request for a left shoulder arthroscopic capsulotomy:

Medical Treatment Guideline(s) 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 (ACOEM), 2nd Edition, (2004), Chapter 9, page 209, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG) – Shoulder Chapter, Surgery for Adhesive Capsulitis section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert

Reviewer found the section of the MTUS used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 9/29/2010 and the utilization review determination listed the diagnosis as bilateral frozen shoulders. The medical records received and reviewed indicate the employee has undergone a left shoulder extensive arthroscopic debridement, arthroscopic decompression of the subacromial space, synovectomy and capsular contracture release, and manipulation under anesthesia with an injection. The employee has continued to have significant reduced left shoulder range of motion (ROM) in abduction and flexion. A request was submitted for a left shoulder arthroscopic capsulotomy.

The ACOEM Guidelines indicate surgical consultation may be indicated for patients who have: red-flag conditions; activity limitation for more than four months, plus a surgical lesion; failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus a surgical lesion; and/or 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 ACOEM Guidelines also indicate surgical considerations depend on the working or imaging-confirmed diagnosis of the shoulder complaint. Additionally, the ACOEM Guidelines indicate that for post-surgical rehabilitation, key indicators for further assessment and treatment include prolonged course, multiple surgical procedures, and use of narcotic medications.

The medical records submitted and reviewed indicate the employee has not complied with the prescribed rehab protocol following the most recent right shoulder surgery on 5/10/2013. The records do not establish that the employee would be compliant with the same rehab protocol following the proposed surgical procedure. Additionally, the records do not show that the employee has failed a recent trial of physical therapy for the left shoulder. The documentation does not support the request and the guideline criteria are not met. The request for a left shoulder arthroscopic capsulotomy is not medically necessary and appropriate.

2) Regarding the request for post-operative physical therapy (3 times a week for 4 weeks):

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer relied on the Postsurgical Treatment Guidelines, Adhesive Capsulitis section, which is part of the California Medical Treatment Utilization Schedule (MTUS).

Rationale for the Decision:

The employee was injured on 9/29/2010 and the utilization review determination listed the diagnosis as bilateral frozen shoulders. The medical records received and reviewed indicate the employee has undergone a left shoulder extensive arthroscopic debridement, arthroscopic decompression of the subacromial

space, synovectomy and capsular contracture release, and manipulation under anesthesia with an injection. The employee has continued to have significant reduced left shoulder range of motion (ROM) in abduction and flexion. A request was submitted for post-operative physical therapy (3 times a week for 4 weeks).

The request is for post-operative physical therapy. The MTUS Postsurgical Treatment Guideline indicates 24 visits over 14 weeks are appropriate for adhesive capsulitis. However, the requested surgical procedure that precedes the physical therapy is not medically necessary and appropriate. Therefore, the request for post-operative physical therapy (3 times a week for 4 weeks) is not medically necessary and appropriate.

3) Regarding the request for a continuous passive motion (CPM) rental for 4 weeks:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter. The provider did not dispute the lack of guidelines used by the Claims Administrator. The Expert Reviewer determined that the California Medical Treatment Utilization Schedule (MTUS) does not address the requested treatment. The Expert Reviewer relied on the Official Disability Guidelines (ODG), Shoulder Chapter, Continuous Passive Motion section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee was injured on 9/29/2010 and the utilization review determination listed the diagnosis as bilateral frozen shoulders. The medical records received and reviewed indicate the employee has undergone a left shoulder extensive arthroscopic debridement, arthroscopic decompression of the subacromial space, synovectomy and capsular contracture release, and manipulation under anesthesia with an injection. The employee has continued to have significant reduced left shoulder range of motion (ROM) in abduction and flexion. A request was submitted for a continuous passive motion (CPM) rental for 4 weeks.

The request is for post-operative CPM therapy. The ODG indicates that CPM may be an option for adhesive capsulitis for up to 5 days a week for 4 weeks. However, the requested surgical procedure that precedes the CPM therapy is not medically necessary and appropriate. Therefore, the request for a continuous passive motion (CPM) rental for 4 weeks is not medically necessary and appropriate.

4) Regarding the request for a thermal compression therapy rental for 21 days:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator did not cite any evidence-based criteria in its utilization review determination letter. The provider did not dispute the lack of guidelines

used by the Claims Administrator. The Expert Reviewer determined that the California Medical Treatment Utilization Schedule (MTUS) does not address the requested treatment. The Expert Reviewer relied on the Official Disability Guidelines (ODG), Knee Chapter, Durable Medical Equipment section, which is a medical treatment guideline that is not part of the MTUS.

Rationale for the Decision:

The employee was injured on 9/29/2010 and the utilization review determination listed the diagnosis as bilateral frozen shoulders. The medical records received and reviewed indicate the employee has undergone a left shoulder extensive arthroscopic debridement, arthroscopic decompression of the subacromial space, synovectomy and capsular contracture release, and manipulation under anesthesia with an injection. The employee has continued to have significant reduced left shoulder range of motion (ROM) in abduction and flexion. A request was submitted for a thermal compression therapy rental for 21 days.

The request is for post-operative thermal compression therapy. The ODG indicates that it may be appropriate if there is a documented medical need. The requested surgical procedure that precedes the thermal compression therapy is not medically necessary and appropriate. Medical need for this device has not been established. Therefore, the request for a thermal compression therapy rental for 21 days 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/dj

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.