

Notice of Independent Medical Review Determination

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/26/2013
Date of Injury: 1/30/2009
IMR Application Received: 8/16/2013
MAXIMUS Case Number: CM13-0003749

- 1) MAXIMUS Federal Services, Inc. has determined the request for **right shoulder arthroscopy with subacromial decompression is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **ThermoCool unit with compression is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **abduction arm sling is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **home health for dressing changes and wound care four hours a day for two weeks is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **post-op physical therapy twelve sessions for left knee is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/16/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 with subacromial decompression is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **ThermoCool unit with compression is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **abduction arm sling is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **home health for dressing changes and wound care four hours a day for two weeks is not medically necessary and appropriate.**
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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:

This is a 64 year old male claimant who reportedly injured his left knee on 01/30/2009. He underwent a left total knee replacement in 2009 with complication of a post-operative deep vein thrombosis and placed on Lovenox. A left knee revision arthroplasty was performed in March 2013. The medical records noted the claimant at present with right shoulder pain secondary to the use of a cane with diagnoses of right shoulder impingement syndrome. A right shoulder MRI performed on 12/22/11 showed a full thickness tear of the supraspinatus tendon, hypertrophic osteoarthropathy of the AC joint, mild osteoarthritic changes of the glenohumeral joint and no fracture or dislocation. A 10/25/12 physician record noted the claimant followed for right shoulder pain and bilateral knee pain. The claimant continued to report right shoulder pain at subsequent physician visits. There was right shoulder tenderness to the greater tuberosity and subacromial space with positive impingement sign and 4/5 strength in forward flexion and external/ internal rotation. Diagnoses included right shoulder

impingement syndrome. A 06/27/13 physician record of Dr. [REDACTED] noted the claimant with continued right shoulder pain despite extensive treatment. A request for right shoulder subacromial decompression was pending. Examination findings included right shoulder tenderness to the greater tuberosity and subacromial space. Forward flexion was 160, abduction 160 and external and internal rotation of 60 each. There was positive impingement sign, 4/5 strength in forward flexion and external /internal rotation and no glenohumeral instability. Diagnoses included right shoulder impingement syndrome. The claimant was off work status. A 08/29/13 evaluation with Dr. [REDACTED] revealed the claimant with continued right shoulder pain. The claimant was also evaluated for post-operative total knee revision and was noted to be doing well. The record noted the claimant continued to take medication for symptom relief and was not attending regular physical therapy. A right shoulder examination revealed tenderness to the greater tuberosity and subacromial space, forward flexion 150, abduction 150 and external / internal rotation 50. There was positive impingement signs and 4/5 strength in forward flexion and external/ internal rotation. Diagnoses remained unchanged. Physical therapy to the right shoulder was requested times 12 sessions and additional steroid injection was considered. Conservative treatment for the right shoulder had included physical therapy, Naprosyn , hydrocodone and off work status. The request for right shoulder arthroscopy with subacromial decompression was previously denied on peer review 07/26/13 as conservative care for the right shoulder was not provided. There was good right shoulder motion and strength and functional deficit was not demonstrated and therefore, guideline criteria were not met.

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
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for right shoulder arthroscopy with subacromial decompression :

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), Shoulder Surgery for Rotator Cuff Tear, which is not part of MTUS.

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

Rationale for the Decision:

CA MTUS with respect to surgery for impingement states, “Conservative care, including cortisone injections, can be carried out for at least three to six months before considering surgery”. The records indicate the employee treating for right shoulder pain secondary to use of a cane following left knee arthroplasty in 2009 and revision arthroplasty in March 2013. Physician records of 2013 note the employee with continued complaints of right shoulder pain and seen simultaneously for left knee post-operative follow-up. Right shoulder examination findings reveal tenderness to the greater tuberosity and subacromial space. Conservative treatment specifically for the right shoulder is unclear. In addition, it is unclear what has changed regarding the right shoulder pain as it appears to be a longstanding complaint. **The request for right shoulder arthroscopy with subacromial decompression is not medically necessary and appropriate.**

2) Regarding the request for ThermoCool unit with compression :

Since the primary procedure is not medically necessary and appropriate, the associated services are not medically necessary and appropriate.

3) Regarding the request for abduction arm sling :

Since the primary procedure is not medically necessary and appropriate, the associated services are not medically necessary and appropriate.

4) Regarding the request for home health for dressing changes and wound care four hours a day for two weeks :

Since the primary procedure is not medically necessary and appropriate, the associated services are not medically necessary and appropriate.

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

Section of the Medical Treatment Utilization Schedule 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.

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, Postoperative Physical Therapy: Knee, which is part of MTUS.

Rationale for the Decision:

The employee underwent a revision left knee arthroplasty and physical therapy would be appropriate post-operative treatment. **The request for post-op physical therapy twelve sessions for left knee is 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
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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.