
Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/11/2013
Date of Injury: 5/24/2012
IMR Application Received: 7/31/2013
MAXIMUS Case Number: CM13-0005114

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left shoulder arthroscopy is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **subacromial decompression is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **distal clavicle excision is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 2 times a week for 3 weeks for the left shoulder is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **pre operative medical clearance for the left shoulder is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **shoulder sling is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **abduction pillow is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/12/2013. 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 **left shoulder arthroscopy** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **subacromial decompression** is not **medically necessary and appropriate**.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **distal clavical excision** is not **medically necessary and appropriate**.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 2 times a week for 3 weeks for the left shoulder** is not **medically necessary and appropriate**.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **pre operative medical clearance for the left shoulder** is not **medically necessary and appropriate**.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **shoulder sling** is not **medically necessary and appropriate**.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **abduction pillow** 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 Physical Medicine and Rehabilitation, 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 patient's underlying date of injury is 05/24/2012. The date of initial Utilization Review decision is 08/07/2013. The original mechanism of injury is that a pressured tote lid blew off and a bolt hit the patient. The patient's diagnoses include bilateral shoulder impingement syndrome refractory to cortisone injection and bilateral shoulder acromioclavicular joint osteoarthritis worse on the left.

On 07/01/2013, orthopedist Dr. [REDACTED] requested authorization for a left shoulder arthroscopy with subacromial decompression and distal clavicle excision, noting the patient would need medical clearance prior to surgery and would need 6-12 weeks of physical therapy postoperatively and durable medical equipment in the form of a left shoulder sling. A request for left shoulder surgical intervention was noncertified on 07/11/2013 with the rationale that there was no recent physical examination and that there was no specific response documented to injection and since imaging did not reveal significant acromioclavicular joint degeneration. Past treatment has included chiropractic treatment, a TENS unit, shock wave therapy, physical therapy, and medication. The patient is noted to have a past history of a cervical fusion. Dr. [REDACTED] noted that on exam of the bilateral shoulders, the patient had decreased range of motion and weakness as well as positive impingement signs which were consistent with the pathology shown on MRI imaging.

The Utilization Review non-certification of 08/07/2013 notes that there was limited information provided regarding response to the patient's past surgical injection and noted that the patient was scheduled for a qualified medical examination 08/14/2013, and it would be appropriate for the patient to first undergo that evaluation in order to determine whether surgery was indicated.

An MRI of the left shoulder of 06/19/2013 demonstrated mild degenerative changes of the acromioclavicular joint with no labral or tendon tear.

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 left shoulder arthroscopy:

The Medical Treatment Guidelines 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, Shoulder Complaints, table 9-6, pages 209-211, which is part of MTUS, and the Official Disability Guidelines, (ODG), Shoulder Chapter, which is not part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (ODG), Treatment of Workers' Compensation/Shoulder/Surgery for Impingement Syndrome.

Rationale for the Decision:

The Official Disability Guidelines (ODG) states regarding surgery for impingement syndrome the criteria include, "Objective clinical findings...weak or absent abduction; may also demonstrate atrophy; and temporary relief of pain with anesthetic injection...plus imaging clinical findings; conventional x-rays and MRI or alternative arthrogram show positive evidence of impingement." At this time, the clinical findings are nonspecific and not clearly quantitative. Moreover, the imaging findings do not clearly show positive evidence of impingement. Overall, the guidelines and medical records outline a situation which would support ongoing conservative treatment. The guidelines and medical records do not substantiate an indication for surgical intervention. **The request for left shoulder arthroscopy is not medically necessary and appropriate.**

2) Regarding the request for subacromial decompression :

The Medical Treatment Guidelines 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, Shoulder Complaints, table 9-6, pages 209-211, which is part of MTUS, and the Official Disability Guidelines, (ODG), Shoulder Chapter, which is not part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, (ODG), Treatment of Workers' Compensation/Shoulder/Surgery for Impingement Syndrome.

Rationale for the Decision:

The Official Disability Guidelines (ODG) states regarding surgery for impingement syndrome the criteria include, "Objective clinical findings...weak or absent abduction; may also demonstrate atrophy; and temporary relief of pain with anesthetic injection...plus imaging clinical findings; conventional x-rays and MRI or alternative arthrogram show positive evidence of impingement." At this time, the clinical findings are nonspecific and not clearly quantitative. Moreover, the imaging findings do not clearly show positive evidence of impingement. Overall, the guidelines and medical records outline a situation which would support ongoing conservative treatment. The guidelines and medical records do not substantiate an indication for surgical intervention. **The request for subacromial decompression is not medically necessary and appropriate.**

3) Regarding the request for distal clavical excision :

The Medical Treatment Guidelines 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, Shoulder Complaints, table 9-6, pages 209-211, which is part of

MTUS, and the Official Disability Guidelines, (ODG), Shoulder Chapter, which is not part of MTUS.

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

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Rationale for the Decision:

The Official Disability Guidelines (ODG) states regarding surgery for impingement syndrome the criteria include, "Objective clinical findings...weak or absent abduction; may also demonstrate atrophy; and temporary relief of pain with anesthetic injection...plus imaging clinical findings; conventional x-rays and MRI or alternative arthrogram show positive evidence of impingement." At this time, the clinical findings are nonspecific and not clearly quantitative. Moreover, the imaging findings do not clearly show positive evidence of impingement. Overall, the guidelines and medical records outline a situation which would support ongoing conservative treatment. The guidelines and medical records do not substantiate an indication for surgical intervention. **The request for distal clavicle excision is not medically necessary and appropriate.**

4) Regarding the request for physical therapy for the left shoulder 2 times a week for 3 weeks :

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

5) Regarding the request for pre operative medical clearance for the left shoulder:

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

6) Regarding the request for shoulder sling:

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

7) Regarding the request for abduction pillow:

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

/cmol

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.