

**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:	7/9/2013
Date of Injury:	8/5/2012
IMR Application Received:	7/31/2013
MAXIMUS Case Number:	CM13-0005193

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Right Shoulder Arthroscopy** is 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 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/15/2013. 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 is 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 46-year-old female who reported injury on 08/05/2012. The mechanism of injury was stated to be a slip and fall. The patient was noted to have an MRI of the right shoulder on 10/24/2012 with an official read per [REDACTED], MD, PhD, with an official reading of there is a small amount of fluid seen in the right shoulder joint; no leak into the subacromial space; there is a mild amount of fluid seen in the biceps tendon sheath consistent with tenosynovitis changes; no evidence for tear or SLAP type of injury detected. The patient was noted to have undergone an EMG/NCS on 10/19/2012 with official read per [REDACTED], MD, which revealed the following: no electrophysiologic evidence to support entrapment neuropathy of the median, ulnar, or radial nerves; no electrophysiologic evidence to support distal peripheral neuropathy or motor radiculopathy in the upper extremities. The patient was noted to have an x-ray of the right shoulder on 10/17/2012 with an official read per [REDACTED], MD, which revealed a normal x-ray study of the right shoulder. The patient was noted to have a physical therapy re-evaluation dated 06/27/2013 with the first session listed being 05/16/2013 which revealed the following: on active range of motion flexion on 05/16/2013 was within normal limits, on 06/27/2013 was 150 degrees on the right; extension on the right was noted to be within normal limits on 05/16/2013, on 06/27/2013 was noted to be 52 degrees; abduction was noted to be within normal limits on 05/16/2013, on 06/27/2013 it was noted to be 140 degrees; and internal rotation on 05/16/2013 was noted to be within normal limits, and on 06/27/2013 it was noted to be at 36 degrees. The patient's gross strength both on 05/16/2013 and 06/27/2013 were noted to be 4-/5 on the right. The patient was noted to have tenderness over the right UT, rhomboids, medial aspect of the right elbow along with a positive muscle spasm to the right UT. It was further stated on the re-evaluation that the patient has had cortisone injections that provided 2 months of relief for involved but the symptoms have regressed. The office note dated 06/05/2013 revealed the patient had a right shoulder positive impingement test. Abduction was restricted at 150/180 degrees, flexion 160/180 degrees. Tenderness was noted at the acromioclavicular joint as well as the

bicipital tendon long head. The patient was noted to complain of severe right shoulder pain with no work at shoulder level or above and upper extremity pain. The treatment plan was stated to be requesting authorization for the right shoulder arthroscopic surgery due to the positive MRI findings as well as the recommendation of Dr. [REDACTED]

**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 [REDACTED]
- Medical Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for Right Shoulder Arthroscopy:**

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), which is not part of the Medical Treatment Utilization Schedule (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 Official Disability Guidelines, Shoulder Chapter, Online Version, which is not part of MTUS.

Rationale for the Decision:

MTUS/ACOEM Guidelines do not address the request for right shoulder arthroscopy. The Official Disability Guidelines recommend the criteria for a diagnostic arthroscopy to be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Clinical documentation submitted for review indicated the imaging is inconclusive and the employee is noted to have pain despite conservative care. **The request for Right Shoulder Arthroscopy 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  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.