

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

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**Notice of Independent Medical Review Determination**

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Dated: 11/13/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/20/2013
Date of Injury:	3/16/2007
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0005289

- 1) MAXIMUS Federal Services, Inc. has determined the request for **18 sessions of home health services with physical therapy for the right shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit rental for the right shoulder is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **reverse right total shoulder replacement is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **CT scan of the right shoulder is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/20/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. 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 **18 sessions of home health services with physical therapy for the right shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **cold therapy unit rental for the right shoulder is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **reverse right total shoulder replacement is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **CT scan of the right shoulder 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 Preventive Medicine and Occupational 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.

### **Expert Reviewer Case Summary:**

The applicant was injured on 3/16/2007 and has been treated with analgesic medications, transfer of care to and from various providers in various specialties, unspecified amounts of acupuncture, and prior shoulder surgery. An MRI of the right shoulder dated 8/2/2013 demonstrated postoperative changes and mild-to-moderate arthritic changes, with evidence of prior rotator cuff repair surgery. The applicant has also reports psychiatric complaints of sleep disturbance. The most recent progress report dated 7/24/2013 is notable for comments that the applicant's right shoulder is the most significant source of complaints. He exhibits 140 degrees of flexion with only 4/5 strength appreciated. Palpable tenderness is noted. The provider recommended treatment with Vicodin and Lidoderm for pain relief. The applicant's shoulder arthroplasty is apparently pending.

### **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 18 sessions of home health services with physical therapy for the right shoulder:**

##### 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pages 207-208, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 51, which is part of the MTUS.

##### Rationale for the Decision:

The Chronic Pain guidelines suggest that home health services are only needed to facilitate delivery of medically necessary services in individuals who are home bound. The records submitted for review lack of documentation why the employee would be home bound and/or unable to participate in conventional outpatient physical therapy even if the total shoulder arthroplasty had been approved. Since the primary procedure is not medically necessary, none of the associated services are medically necessary. **The request for 18 sessions of home health services with physical therapy for the right shoulder is not medically necessary and appropriate.**

#### **2) Regarding the request for cold therapy unit rental for the right shoulder:**

##### 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pages 207-208, which is part of the 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 (ODG), Shoulder Chapter, which is not part of the MTUS.

Rationale for the Decision:

The ODG support up to seven days of postoperative cryotherapy following total shoulder arthroplasty. Since the primary procedure is not medically necessary, none of the associated services are medically necessary. **The request for cold therapy unit rental for the right shoulder is not medically necessary and appropriate.**

**3) Regarding the request for reverse right total shoulder replacement:**

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), 11<sup>th</sup> Edition (web), 2013, Shoulder – Arthroplasty, which is not part of the MTUS, and the Milliman Care Guidelines Inpatient and Surgical Care 16<sup>th</sup> Edition, Reverse Shoulder Arthroplasty, which is not part of the 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 3<sup>rd</sup> Edition), which is not part of the MTUS.

Rationale for the Decision:

The ACOEM guidelines suggest that total shoulder arthroplasty is moderately recommended for patients with moderate-to-severe arthritis. The records submitted for review include a shoulder MRI dated 8/2/2013 which demonstrates mild-to-moderate osteoarthritic change within the glenohumeral joint, as opposed to the requisite moderate-to-severe radiographic arthritis needed to support an indication for total shoulder placement. The guidelines further recommend that criteria for total shoulder replacement includes evidence of failure of two different NSAIDs, activity modification, exercises, viscosupplementation, and/or glucocorticoid injections. In this case, it is not documented that the employee has tried and failed conservative therapies to meet these criteria. **The request for reverse right total shoulder replacement is not medically necessary and appropriate.**

**4) Regarding the request for CT scan of the right shoulder:**

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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pages 207-208, which is part of the MTUS, and the Official Disability Guidelines (ODG), 11<sup>th</sup> Edition (web), 2013, Shoulder, which is not part of the 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 Shoulder Complaints Chapter (ACOEM Practice Guidelines, 3<sup>rd</sup> Edition), which is not part of the MTUS.

Rationale for the Decision:

The ACOEM guidelines suggest that x-ray is the primary diagnostic test for diagnosing degenerative joint disease. CT scanning is recommended only for preoperative planning purposes. The records submitted for review indicate the employee underwent a recent MRI imaging establishing the presence of mild-to moderate osteoarthritis. Further, there is no indication of the specific purpose of the requested CT scan at this stage in the employee's treatment. **The request for CT scan of the right shoulder 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,

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.