

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

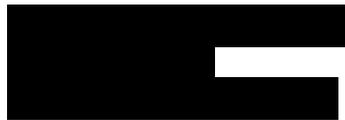
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Notice of Independent Medical Review Determination

Dated: 12/17/2013



Employee:	
Claim Number:	
Date of UR Decision:	7/19/2013
Date of Injury:	1/20/2012
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0006121

- 1) MAXIMUS Federal Services, Inc. has determined the request for **post-op physical therapy 2 times a week for twelve weeks for left shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op vascutherm for left shouldder thirty day rental is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **post-op CPM for left shoulder thirty day Rental is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/23/2013. 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 **post-op physical therapy 2 times a week for twelve weeks for left shoulder is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **post-op vascutherm for left shouldder thirty day rental is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **post-op CPM for left shoulder thirty day Rental is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Physician Reviewer 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 patient is a 66-year-old male who reported an injury on 01/20/2012 secondary to a fall. Notes indicate that the patient was diagnosed with a left shoulder rotator cuff tear, with current request for post-op physical therapy 2 times a week for 12 weeks for the left shoulder and a post-op vascutherm for the left shoulder 30 day rental, as well as a post-op CPM machine for the left shoulder 30 day rental. Notes detail the patient is status post a right shoulder massive rotator cuff repair in April of 2012, with the patient having noted to be experiencing pain to the left shoulder from favoring the right shoulder. Notes indicate that the patient underwent MRI imaging of the left shoulder which revealed a rotator cuff repair. Summary notes indicated that the patient received an evaluation on 06/13/2013; notes showed that the patient has persistent left shoulder symptoms despite undergoing cortisone injections. Additional documentation indicates that the patient was approved to undergo surgery for the left shoulder with arthroscopic rotator cuff repair on 08/12/2013.

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:



1) Regarding the request for post-op physical therapy 2 times a week for twelve weeks for left 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 California Medical Treatment Utilization Schedule, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pg.10, pg. 27, which is part of the MTUS.

Rationale for the Decision:

The California MTUS recommend postoperative physical therapy following rotator cuff repair at a maximum of 24 visits over 14 weeks for arthroscopic procedures and 30 visits over 18 weeks for open procedures. Furthermore, guidelines indicate the recommendation for the initial course of therapy as representative of one-half the number of sessions indicated for the general course of therapy for the specified surgery. The medical records provided for review reflects that the employee has been certified per the documentation for a left shoulder arthroscopic rotator cuff repair, 12 initial sessions of physical therapy may be warranted. However, given that the request exceeds the recommendation of the guidelines, it does not meet the criteria. **The request for post-op physical therapy 2 times a week for 12 weeks for left shoulder is not medically necessary and appropriate.**

2) Regarding the request for post-op vascultherm for left shouldder thirty day rental:

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 California Medical Treatment Utilization Schedule which is part of the MTUS

The Physician 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 Physician Reviewer based his/her decision on Official Disability Guidelines (ODG), Shoulder Chapter, which is not part of the MTUS.

Rationale for the Decision:

The California MTUS/ACOEM Guidelines does not specifically address a postoperative vascultherm device for the left shoulder. The Official Disability Guidelines indicate that continuous flow cryotherapy may be recommended following surgical treatment; however, it is not recommended for nonsurgical treatment. Furthermore, guidelines indicate that postoperative use may generally be up to 7 days including home use. The medical records provided for review identifies the current request for post-op vascultherm for the left shoulder for a 30 day rental exceeds the recommendation of the guidelines. **The request for post-op vascultherm for left shoulder 30 day rental is not medically necessary and appropriate.**

3) Regarding the request for post-op CPM for left shoulder thirty day Rental:

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 California Medical Treatment Utilization Schedule, which part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on Official Disability Guidelines (ODG), Shoulder Chapter, which is not part of the MTUS.

Rationale for the Decision:

The California MTUS/ACOEM Guidelines do not specifically address the use of a postoperative continuous passive motion machine for the shoulder. The Official Disability Guidelines indicate that continuous passive motion is not recommended following rotator cuff repair or for nonsurgical treatment. The Agency for Healthcare and Quality conducted a comparative effectiveness review and concluded that evidence on the comparative effectiveness and harms of various operative and non operative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and 1 study found no difference in range of motion or strength. **The request for post-op CPM for the left shoulder 30 day rental 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

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th 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.