
Notice of Independent Medical Review Determination

Dated: 9/20/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

5/17/2013

1/8/2013

6/19/2013

CM13-0000565

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/19/2013 disputing the Utilization Review Denial dated 5/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 **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 Orthopaedic 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated May 17, 2013.

DECISION/CLINICAL RATIONALE AS STATED IN THE PEER REVIEWER'S REPORT:

From peer reviewers report: REQUEST: right shoulder arthroscopy with rotator cuff repair, date of service 04/12/13
SUMMARY OF TREATMENT/CASE HISTORY: The patient is a 55-year-old male who injured his right shoulder on 01/08/13 in an industrial incident. His treatment has consisted of one session of physical therapy, medication and activity modification. Subacromial steroid injection was not performed. An MRI was performed which according to the previous utilization review report showed a partial thickness rotator cuff tear. The MRI report was not available for review. The patient did not want conservative care and insisted on surgery which was therefore provided. The operative report suggests a 1 cm cuff tear and bicipital fraying for which rotator cuff repair and tenodesis was performed. EXPLANATION OF FINDINGS: In my judgment, the clinical information provided fails to support the surgery performed on 04/12/13. The ACOEM Guidelines, section on Shoulder Disorders states, "Rotator cuff repair is recommended for acute, sub-acute and chronic rotator cuff tear. Rotator cuff repair is moderately recommended for treatment of small, medium or large tears (<5cm). Indications: All of the following: 1) shoulder joint pain; 2) reduced ROM of the shoulder or impaired function; 3) imaging findings by MRI, MR arthrography or ultrasound of rotator cuff tear. Patient must agree to participate fully in post operative active rehabilitation and understand there is a long recovery time." The Official Disability Guidelines were also referenced which require the following: "Conservative care: recommend three to six months. Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature, plus Subjective clinical findings: Pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases), plus Objective

clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over the rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test), plus Imaging clinical findings: conventional x-rays, AP and true lateral or axillary view and Gadolinium MRI, ultrasound or arthrogram shows positive evidence of deficit in the rotator cuff." The patient's surgery was performed without documentation of a full-thickness tear according to the medical records submitted for review. The patient's conservative treatment had consisted of one session of therapy and medication, which fails to meet the guideline criteria for surgery. In the absence of incontrovertible proof that the patient was known to have a large full-thickness tear prior to the surgery date, the full conservative treatment for impingement would be required. As it was not completed, the surgery cannot be recommended on a retrospective basis to have been medically necessary. Therefore, based on the evidence-based guidelines and medical evidence provided, this request has been determined to not be supported for medical necessity. REFERENCES USED IN SUPPORT OF DECISION: ACOEM Guidelines Official Disability Guidelines

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 for Independent Medical Review
- Utilization Review from Claims Administrator
- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13:

Medical Treatment Guideline(s) 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, Chapter 9, page 210, which is part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), which is a medical treatment guideline that is not part of the MTUS, but did not cite a specific section. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the right shoulder in an industrial accident on 1/8/2013. The records submitted and reviewed indicate the employee has utilized Norco 2 to 3 times per day and ice twice a day, as well as Thera-Band and Relafen. The records also indicate that as of 1/23/2013, the employee had attended 1 of 6 approved physical therapy sessions for right shoulder pain. A clinical note dated 1/29/2013 indicates the employee was recommended for surgical interventions prior to his date of injury and references an MRI of the right shoulder that revealed a partial-thickness rotator cuff tear. A retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 was submitted.

The ACOEM Guidelines indicate that for partial-thickness rotator cuff tears, surgery is reserved for cases in which the patient fails conservative therapy for 3

months. The employee did not exhaust lower levels of conservative treatment, as the clinical notes document completion of one session of physical therapy. Additionally, the clinic notes did not include an imaging report of the employee's right shoulder. Thus, as of 4/12/2013, the employee would not have been an eligible surgical candidate for right shoulder pain complaints, as there is a lack of evidence of exhaustion of conservative treatment, and lack of an imaging study of the right shoulder. The guideline criteria were not met prior to the surgical intervention. The retrospective request for arthroscopy, shoulder, surgical, capsulorrhaphy provided on 4/12/13 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;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

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