

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
P.O. Box 138009  
Sacramento, CA 95813-8009  
(855) 865-8873 Fax: (916) 605-4270



**Notice of Independent Medical Review Determination**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested left shoulder arthroscopy, extensive debridement, subacromial decompression, and manipulation under anesthesia **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested pre-operative electrocardiogram (EKG) and labs **are medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested post operative polar care unit **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the requested first round of physical therapy four (4) times a week for two (2) weeks **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the requested second round of physical therapy three (3) times a week for two (2) weeks **is not medically necessary and appropriate.**

- 6) MAXIMUS Federal Services, Inc. has determined the requested third round of physical therapy two (2) times a week for six (6) weeks **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 6/10/2013 disputing the Utilization Review Denial dated 5/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/11/2013. 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 requested left shoulder arthroscopy, extensive debridement, subacromial decompression, and manipulation under anesthesia **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the requested pre-operative electrocardiogram (EKG) and labs **are medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the requested post operative polar care unit **is medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the requested first round of physical therapy, four (4) times a week for two (2) weeks, **is medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the requested second round of physical therapy, three (3) times a week for two (2) weeks, **is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the requested third round of physical therapy, two (2) times a week for six (6) weeks, **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 Orthopedic Surgery and is licensed 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 24, 2013.

According to the medical records, the patient is a 53-year-old male who sustained an industrial injury in January 23, 2013. As per the DFR from Dr. [REDACTED] MD, the injury reportedly happened suddenly. The patient believes his left arm was down and so the injury was more of a blow to the anterior shoulder than a wrenching of the arm. Treatment has included physical therapy and cortisone injection to the left shoulder which reportedly helped. The current request is from Dr. [REDACTED] MD.

### **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 determination by [REDACTED] (dated 5/24/13)
- Employee medical records from [REDACTED] MD (dated 1/24/13-5/3/13)
- Employee medical records from [REDACTED] (dated 5/14/13)
- MRI report from [REDACTED] (dated 2/26/13)
- Employee medical records from [REDACTED], MD (dated 3/20/13-5/15/13)
- Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9) pg. 209-211
- Appendix C – Postsurgical Treatment Guidelines Evidence-Based Reviews (May, 2009), Rotator Cuff Syndrome/Impingement Syndrome

### **1) Regarding the request for left shoulder arthroscopy, extensive debridement, subacromial decompression, manipulation under anesthesia:**

#### Medical Treatment Guideline(s) 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) pg. 209-211, which is part of the Medical Treatment Utilization Schedule (MTUS). 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 sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior

labral tear, moderate inferior capsular sprain, and partial tearing of the inferior glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

MTUS indicates surgery for impingement syndrome should not be considered until three to six months of conservative care has been completed. The medical record reflects the employee continues to have persistent left shoulder pain following more than five months of conservative care, and the medical record of 5/15/13 indicates positive impingement signs. The criteria for surgery for impingement syndrome has been met. The left shoulder arthroscopy, extensive debridement, subacromial decompression, manipulation under anesthesia **is medically necessary and appropriate.**

**2) Regarding the request for pre-operative electrocardiogram (EKG) and labs:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the medical treatment guideline from the Institute for Clinical Systems Improvement (ICSI). Preoperative Evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p. 26, which is not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that no section of MTUS was applicable. The Expert Reviewer found no applicable and relevant Medical Treatment Guideline, including the Guideline cited by the Claims Administrator. The Expert Reviewer found no Nationally Recognized Professional Standard that was applicable and relevant to the issue at dispute, The Expert Reviewer found no Expert Opinion that was applicable and relevant to the issue. Per the Strength of Evidence hierarchy establish by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on generally accepted standards of medical practice.

Rationale for the Decision:

The employee sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior labral tear, moderate inferior capsular sprain, and partial tearing of the inferior glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

MTUS does not address the need for pre-operative electrocardiogram (EKG) and labs. Based on the employee's age of 53, most hospital protocol would require pre-operative labs and EKG as part of the standard of care. The pre-operative EKG and labs **are medically necessary and appropriate.**

**3) Regarding the request for post operative polar care unit:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG): Shoulder Chapter, Continuous-flow cryotherapy which is not part of the Medical Treatment Utilization Schedule (MTUS). 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 sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior labral tear, moderate inferior capsular sprain, and partial tearing of the inferior glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

MTUS does not address the need for post operative cold therapy units, therefore, ODG was referenced. ODG does recommend the unit as an option after surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The request for post operative polar care unit **is medically necessary and appropriate.**

**4) Regarding the request for first round of physical therapy, four (4) times a week for two (2) weeks:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, shoulder, rotator cuff syndrome/Impingement syndrome, which is part of the Medical Treatment Utilization Schedule (MTUS). 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 sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior labral tear, moderate inferior capsular sprain, and partial tearing of the inferior glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

Surgery has been deemed to be medically necessary and appropriate, and most individuals can successfully rehab from this particular surgery with 24 visits. The requested eight sessions would be less than 50% of the overall recommended number per the Guidelines. The first round of postoperative physical therapy,

four (4) times a week for two (2) weeks, **is medically necessary and appropriate.**

**5) Regarding the request for second round of physical therapy, three (3) times a week for two (2) weeks:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, shoulder, rotator cuff syndrome/Impingement syndrome, which is part of the Medical Treatment Utilization Schedule (MTUS). 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 sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior labral tear, moderate inferior capsular sprain, and partial tearing of the inferior glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

MTUS indicates continued physical therapy would be indicated if the employee continued to have ongoing symptomatology that would warrant continuation of therapy. The employee has yet to undergo surgery, and therefore, the outcome and need for the continued therapy is not known. The second round of physical therapy, three (3) times a week for two (2) weeks, **is not medically necessary and appropriate.**

**6) Regarding the request for the third round of physical therapy two (2) times a week for six (6) weeks:**

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Postsurgical Treatment Guidelines, shoulder, rotator cuff syndrome/Impingement syndrome, which is part of the Medical Treatment Utilization Schedule (MTUS). 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 sustained an industrial injury to the left shoulder on 1/23/13. The medical records provide and reviewed indicate treatment has included physical therapy and a cortisone injection to the left shoulder. An MRI evaluation of the left shoulder was done on 2/26/13 indicating a superior and posterosuperior labral tear, moderate inferior capsular sprain, and partial tearing of the inferior

glenohumeral ligament at the humeral insertion, an intact rotator cuff, and mild acromioclavicular degenerative changes.

MTUS indicates continued physical therapy would be indicated if the employee continued to have ongoing symptomatology that would warrant continuation of therapy. The employee has yet to undergo surgery, and therefore, the outcome and need for the continued therapy is not known. The third round of physical therapy, two (2) times a week for six (6) weeks, **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, 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.