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**Notice of Independent Medical Review Determination**

Dated: 8/16/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 6/11/2013  
Date of Injury: 2/27/2013  
IMR Application Received: 7/5/2013  
MAXIMUS Case Number: CM13-0000985

- 1) MAXIMUS Federal Services, Inc. has determined the request for a right shoulder Mumford procedure, subacromial decompression and debridement **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an assistant surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for an ice machine **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a deluxe arm sling **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/5/2013 disputing the Utilization Review Denial dated 6/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/8/2013. 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 a right shoulder Mumford procedure, subacromial decompression and debridement **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for an assistant surgeon **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for an ice machine **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for a deluxe arm sling **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 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 June 11, 2013

"This is a 43-year old male with a 2-27-2013 date of injury, when he got out of the passenger side of the tractor trailer he placed his right foot on the step and then his left foot missed the step and he fell backwards and landed on his right shoulder blade. 5/13/13 second opinion report indicates that the patient had previously dislocated both shoulders. The patient reports right-sided AC joint pain, Physical exam demonstrates right shoulder forward flexion 170 degrees, abduction 160 degrees positive impingement sign, and tenderness over the right AC joint. Discussion identifies that if the patient were to fail non operative care, he may be a candidate for diagnostic and operative arthroscopy of the shoulder including addressing the AC joint and evaluation of the shoulder instability at the time of the surgery. 6/5/13 progress report indicates increasing AC joint tenderness. 4/10/13 right shoulder MRI demonstrates widening of the AC joint with a large joint effusion. 4/24/13 right shoulder x-rays demonstrate unremarkable SC joint, even though the MRI report indicated that it was widened. The requesting provider indicates that upon review of the 4/19/13 MRI scan, it appears that the patient has a Hill-Sachs lesion and that the anterior labrum appears to be quite

undamaged. The patient reports a history of prior right shoulder dislocations. Treatment to date has included 6 sessions of physical therapy.”

#### **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 (dated 7/5/2013)
- Utilization Review by [REDACTED] (dated 6/11/2013)
- Medical records from Dr. [REDACTED], MD (dated 2/27/13; 3/1/13)
- Medical Records from [REDACTED] (dated 2/27/13; 3/8/13; 3/15/13; 4/12/13)
- Medical Record from [REDACTED] (dated 4/19/13)
- Medical Records from [REDACTED], MD (dated 4/24/13; 6/5/13; 7/3/13)
- Medical Records from [REDACTED], MD (dated 5/13/13)
- Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9, pg 209-211.
- Official Disability Guidelines (ODG) (latest version), Chapter 3, Shoulder , Continuous Flow Cryotherapy
- Official Disability Guidelines (ODG) (latest version), Chapter 3, Shoulder, Immobilization

#### **1) Regarding the request for a right shoulder Mumford procedure, subacromial decompression and debridement:**

##### 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 a work-related right shoulder injury due to a fall on 2/27/13. The medical records provided and reviewed indicate treatment has included six sessions of physical therapy, an MRI scan which demonstrated evidence of synovitis about the acromioclavicular (AC) joint, and time off of work. The medical report of 5/13/13 notes a negative impingement sign with tenderness over the right AC joint. The request is for a right shoulder Mumford procedure, subacromial decompression and debridement.

ACOEM guidelines allows for surgical consideration when there has been failed conservative treatment. The medical records reviewed indicate the employee’s main issue is with shoulder instability; there is no documentation of a positive impingement; no documentation of an acromioclavicular joint injection for pain control; and no indication that conservative care has been exhausted. The right

shoulder Mumford procedure, subacromial decompression and debridement, **is not medically necessary and appropriate.**

**2) Regarding the request for an assistant surgeon:**

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

The Claims Administrator based its decision on the American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant Surgery in Orthopaedics, 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 stated no section of the MTUS was applicable and relevant to the issue at dispute. The Expert Reviewer stated Milliman Care Guidelines® Inpatient and Surgical Care (17th Edition), which is a Medical Treatment Guideline (MTG) not in the MTUS, was applicable and relevant to the issue at dispute.

Rationale for the Decision:

The employee sustained a work-related right shoulder injury due to a fall on 2/27/13. The medical records provided and reviewed indicate treatment has included six sessions of physical therapy, an MRI scan which demonstrated evidence of synovitis about the acromioclavicular (AC) joint, and time off of work. The medical report of 5/13/13 notes a negative impingement sign with tenderness over the right AC joint. The request is for a right shoulder Mumford procedure, subacromial decompression and debridement.

The Milliman Care Guidelines® do not recommend an assistant surgeon for the requested surgical procedure. The right shoulder Mumford procedure, subacromial decompression and debridement has been deemed not to be medically necessary and appropriate, therefore, an assistant surgeon **is not medically necessary and appropriate.**

**3) Regarding the request for an ice machine:**

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), Chapter 3, Shoulder, 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 that MTUS does not address this issue and the guidelines used by the Claims Administrator are relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related right shoulder injury due to a fall on 2/27/13. The medical records provided and reviewed indicate treatment has included six sessions of physical therapy, an MRI scan which demonstrated evidence of synovitis about the acromioclavicular (AC) joint, and time off of work. The medical report of 5/13/13 notes a negative impingement sign with tenderness over the right AC joint. The request is for a right shoulder Mumford procedure, subacromial decompression and debridement.

The Official Disability Guidelines do support the use of continuous-flow cryotherapy as an option after surgery. The right shoulder Mumford procedure, subacromial decompression and debridement has been deemed not to be medically necessary and appropriate, therefore, an ice machine **is not medically necessary and appropriate.**

**4) Regarding the request for a deluxe arm sling:**

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), Chapter 3, Shoulder, Immobilization, 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 stated no section of the MTUS was applicable and relevant to the issue at dispute. 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 a work-related right shoulder injury due to a fall on 2/27/13. The medical records provided and reviewed indicate treatment has included six sessions of physical therapy, an MRI scan which demonstrated evidence of synovitis about the acromioclavicular (AC) joint, and time off of work. The medical report of 5/13/13 notes a negative impingement sign with tenderness over the right AC joint. The request is for a right shoulder Mumford procedure, subacromial decompression and debridement.

The Official Disability Guidelines do not support shoulder immobilization. The right shoulder Mumford procedure, subacromial decompression and debridement, has been deemed not to be medically necessary and appropriate, therefore, a deluxe arm sling **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.