

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

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Dated: 12/24/2013

|   |  |                              |            |
|---|--|------------------------------|------------|
| <b>IMR Case Number:</b>                                   | CM13-0015589   | <b>Date of Injury:</b>       | 11/15/2001 |
| <b>Claims Number:</b>                                     | ██████████   | <b>UR Denial Date:</b>       | 8/14/2013  |
| <b>Priority:</b>  | Standard   | <b>Application Received:</b> | 8/23/2013  |
| <b>Employee Name:</b>                                     | ██                               |                              |            |
| <b>Provider Name:</b>                                     | ██                               |                              |            |
| <b>Treatment(s) in Dispute Listed on IMR Application:</b> | 0490, 23472-80, 29805, 29824, 29826, 29827, 97110, A4565, E0218, E0218 |                              |            |

DEAR ██,

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
 Medical Director

cc: Department of Industrial Relations, ██

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

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, employee/employee representative, Provider)
- Medical Treatment Utilization Schedule (MTUS)

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 61 year old female was injured on 11/15/01. The most current diagnosis is of a left shoulder near full thickness rotator cuff tear for which surgical intervention (left shoulder arthroscopy, subacromial decompression, mini Mumford procedure, rotator cuff repair) was authorized. At the time of the surgical request, the provider had also requested authorization for a preoperative examination, purchase of a CTU and rental of a CTU, a sling, home exercise kit (pulley), Vicodin 5 mg/500 mg, and OxyContin 20 mg. tablets all of which were non-certified. There is then another document beyond the peer review of August 2013 which recommended denial of the aforementioned treatments that indicated some of these treatments were authorized.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **1. Preoperative Examination is medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM, Chapter 7, page 127, which is not 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 the Official Disability Guidelines (ODG), Low Back Chapter.

The Physician Reviewer's decision rationale:

This employee was to undergo surgery for a left shoulder near full thickness rotator cuff tear. CA MTUS does not address preoperative testing however in looking to Official Disability Guidelines, "These tests are performed to find latent abnormalities, such as anemia or silent heart disease, that could impact how, when, or whether the planned surgical procedure and

concomitant anesthesia are performed". As the employee was to undergo surgical intervention, it would be reasonable to evaluate for any underlying conditions that could impact the surgical outcome and postoperative course and as such the preoperative testing would be considered as medically necessary. **The request for Preoperative Examination is medically necessary and appropriate.**

## **2. Cold Treatment Unit Purchase is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Shoulder Chapter, Continuous Flow Cryotherapy Unit, which is not 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 the Official Disability Guidelines, Shoulder Chapter, Continuous Flow Cryotherapy.

The Physician Reviewer's decision rationale:

CA MTUS does not address cryotherapy however in looking to Official Disability Guidelines, "continuous flow cryotherapy is recommended as an option after surgery" and "postoperative use generally may be up to 7 days including home use". While the use of a cold treatment unit would be appropriate in the postoperative course for a period of 7 days, the guidelines would not support the purchase of the unit and as such the request would not be considered as medically necessary. **The request for Cold Treatment Unit Purchase is not medically necessary and appropriate.**

## **3. Cold Treatment Unit Rental (in days) is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Shoulder Chapter, Continuous Flow Cryotherapy, which is not 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 the Official Disability Guidelines, Shoulder Chapter, Continuous Flow Cryotherapy.

The Physician Reviewer's decision rationale:

CA MTUS does not address cryotherapy however in looking to Official Disability Guidelines, "continuous flow cryotherapy is recommended as an option after surgery" and "postoperative use generally may be up to 7 days including home use". Guidelines would support the use of a cold treatment unit in the postoperative course for a period of 7 days, and as this employee was to undergo surgical intervention in the form of a rotator cuff repair, a rental of a cold therapy unit for a period of 7 days would be recommended as medically necessary. **The request for Cold Treatment Unit Rental (in days) is medically necessary and appropriate.**

## **4. Sling is medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Shoulder Chapter, Postoperative abduction pillow sling, which is not 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 the Official Disability Guidelines, Shoulder Chapter, Postoperative abduction pillow sling.

The Physician Reviewer's decision rationale:

CA MTUS does not address postoperative immobilization. In looking to Official Disability Guidelines, a postoperative abduction pillow sling would be recommended as an "option following open repair of large and massive rotator cuff tears". The proposed surgical intervention in this case was an arthroscopic procedure; it would appear that a simple sling, and not a pillow abduction sling, was requested for postoperative use in this case. Immobilization in the form of a simple sling in the immediate postoperative period would be consistent with the standards of care for the procedure that was to be undertaken and as such the sling would be considered as medically necessary. **The request for Sling is medically necessary and appropriate.**

**5. Home Exercise Kit ( Pulley) is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines, Knee and Leg Chapter, Durable Medical Equipment, which is not 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 the Official Disability Guidelines, Shoulder Chapter, Home Exercise Kits, Physical Therapy guidelines, Rotator Cuff Syndrome/Impingement Syndrome, and Complete Rupture of Rotator Cuff sections.

The Physician Reviewer's decision rationale:

CA MTUS does not address a Home Exercise Kit. Official Disability Guidelines recommend home exercise kits where home exercise programs are recommended. In this case a course of formal physical therapy with education in a self directed exercise program would be expected in the immediate postoperative period and as such, there would not be a specific clinical indication for the requested home exercise kit and it would not be considered as medically necessary. **The request for Home Exercise Kit ( Pulley) is not medically necessary and appropriate.**

**6. Vicodin 5mg/500mg Tablets is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 91, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 77-78, which are part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS with respect to initiating opioid therapy states, "intermittent pain: start with short-acting opioid trying one medication at a time". In that surgical intervention was being undertaken, prescription of Vicodin would be appropriate for the first 4 to 6 weeks postoperatively. Vicodin 5 mg/500 mg #60 would be medically necessary. **The request for Vicodin 5mg/500mg Tablets is medically necessary and appropriate.**

**7. OxyCotin 20mg Tablets is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 92, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 77-78, which are part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS with respect to initiating opioid therapy states, "intermittent pain: start with short-acting opioid trying one medication at a time". The provider in this case requested prescriptions for Vicodin and OxyContin; though pain control is necessary in the postoperative period there would not be a clinical need for OxyContin in addition to Vicodin and as such it would not be recommended as medically necessary. **The request for OxyCotin 20mg Tablets is not medically necessary and appropriate.**

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.



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