

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

Dated: 10/17/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/9/2013

2/8/2013

7/15/2013

CM13-0002299

- 1) MAXIMUS Federal Services, Inc. has determined the request for distal clavicle excision **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for possible rotator cuff repair, possible labral repair **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for right shoulder decompression, debridement **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/15/2013 disputing the Utilization Review Denial dated 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 distal clavicle excision **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for possible rotator cuff repair, possible labral repair **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for right shoulder decompression, debridement **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 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 July 8, 2013:

"According to clinical documentation dated 6/4/13 by [REDACTED], MD, the patient complained of shoulder pain. The patient stood 5 feet and 5 inches in height and weighed 250 pounds. On examination, the patients right shoulder forward flexion was 140 degrees; external rotation was 70 degrees; internal rotation to the mid lumbar level. The acromioclavicular joint was tender. The greater tuberosity and proximal biceps were tender. The rotator cuff strength was 3/5 in the supraspinatus and 4/5 in the infraspinatus and subscapularis. The impingement test was positive. The assessment was symptomatic acromioclavicular joint arthritis and impingement with rotator cuff tear. There was a previous adverse determination dated 06/20/13 whereby [REDACTED], D.O. non-certified the request for right shoulder decompression, debridement, possible rotator cuff repair, possible labral repair, and distal clavicle excision 29826, 29822, 29806, 29827, 29824. The reviewer noted that "MTUS accepted ACOEM Second Edition Chapter 9 indicates treatment should include cortisone injection prior to considering surgical intervention and at this time lacking documentation of subacromial corticosteroid injection the recommendations non certification of the requested 'Right Shoulder Decompression, Debridement, Possible Rotator Cuff Repair, possible Labral Repair, and 'Distal Clavicle Excision as the patient has not exhausted at least 3-8 months of conservative treatment including corticosteroid injection." This is a review for

medical necessity of appeal right shoulder decompression, debridement possible rotator cuff repair, possible labral repair, distal clavicle excision.”

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 (received 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/08/13)
- Employee Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for distal clavicle excision:

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 (ACOEM), 2nd Edition (2008) pg. 560-561 which is not part of 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 but based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg. 210 which is part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 02/08/13 resulting in strain to the right shoulder, and cervical spine. The medical records provided for review indicate treatments have included physical therapy, and medication management. The request is for distal clavicle excision.

The MTUS/ACOEM Guidelines state surgical consultation may be indicated for individuals who have red-flag symptoms, activity limitation, failure to increase ROM, and surgery is reserved for cases failing conservative therapy for three months. In this case, the employee has not exhausted at least 3 to 8 months of conservative treatment. The clinical notes fail to support the requested surgical interventions as there continues to be a lack of documentation evidencing the employee had undergone injection therapy to the right shoulder or physical therapy interventions. The clinical notes show that the employee did present with near normal range of motion to the right shoulder. The request for distal clavicle excision **is not medically necessary and appropriate.**

2) Regarding the request for possible rotator cuff repair, possible labral repair:

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 (ACOEM), 2nd Edition (2008) pg. 560-561 which is not part of 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 but based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg. 210 which is part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 02/08/13 resulting in strain to the right shoulder, and cervical spine. The medical records provided for review indicate treatments have included physical therapy, and medication management. The request is for possible rotator cuff repair, possible labral repair.

The MTUS/ACOEM Guidelines state rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The medical records lack the documentation evidencing the employee had undergone injection therapy to the right shoulder or physical therapy interventions. The clinical notes show that the employee did present with near normal range of motion to the right shoulder. The request for possible rotator cuff repair, possible labral repair **is not medically necessary and appropriate.**

3) Regarding the request for right shoulder decompression, debridement:

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 (ACOEM), 2nd Edition (2008) pg. 560-561 which is not part of 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 but based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pg. 210 which is part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 02/08/13 resulting in strain to the right shoulder, and cervical spine. The medical records provided for review indicate treatments have included physical therapy, and medication management. The request is for right shoulder decompression, debridement.

The MTUS/ACOEM Guidelines state for partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, which involves debridement of

inflamed tissue, burring of the anterior acromion, lysis and, sometimes, removal of the coracoacromial ligament, and possibly removal of the outer clavicle. Surgery is not indicated for individuals with mild symptoms or those whose activities are not limited. The clinical notes show that the employee did present with near normal range of motion to the right shoulder, and lacks the evidence of failing conservative therapy. The request for right shoulder decompression, debridement **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

/hs

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.