

**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: 11/13/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	9/9/2010
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003439

- 1) MAXIMUS Federal Services, Inc. has determined the request for **transcatheter therapy, infusion other than for thrombolysis is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/6/2013. 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 **transcatheter therapy, infusion other than for thrombolysis is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The 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 July 12, 2013

██████████ is a 60 year old (DOB: ██████████) male ██████████ who while doing repetitive/cumulative work sustained work injury on 09/09/10. He is currently working. Right hip, right knee, both feet, left elbow, disc (neck) and right shoulder have been accepted by the carrier. The carrier has objected the claim for mental/physical lower back area, both wrists and internal organs.

### 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 07/25/2013)
- Utilization Review Determination from ██████████ (dated 07/12/2013)
- Employee medical records from ██████████
- Medical Treatment Utilization Schedule (MTUS)

**1. Regarding the request transcatheter therapy, infusion other than for thrombolysis:**

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 Section, Postoperative Pain Pump, which is not part of the MTUS.

The Expert 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 Expert Reviewer based his/her decision of the Official Disability Guidelines, Online Version, Shoulder (Acute & Chronic) Chapter.

Rationale for the Decision:

The Official Disability Guidelines indicate that postoperative pain pumps are not recommended as recent clinical trials do not support the use of pain pumps. The medical records provided for review indicate that the employee was treated conservatively without improvement and underwent right shoulder surgery, and was noted to have had ongoing complaints of pain, weakness, and lack of range of motion following the surgery. **The request for transcatheter therapy, infusion other than for thrombolysis 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;

Paul Manchester, MD, MPH,  
Medical Director

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

/mb

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.