

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: | 7/8/2013 |
| Date of Injury: | 1/29/2007 |
| IMR Application Received: | 7/31/2013 |
| MAXIMUS Case Number: | CM13-0005580 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Pool therapy is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Bilateral shoulder injections is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Theracords Pulley x2 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/8/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/12/2013. 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 **Pool therapy is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Bilateral shoulder injections is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Theracords Pulley x2 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 Physical Medicine and Rehabilitation, 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.

Expert Reviewer Case Summary:

According to the 7/25/13 report from Dr. [REDACTED] the patient has a date of injury of 1/29/07, and currently, has left shoulder flexion and abduction limited to 85 degrees, compared to the right which is 160 degs flexion and 110 abduction. Impingement signs are positive on the right. This is a 57 YO, F with bilateral shoulder impingement. s/p debridement in 2009, and hemiarthroplasty, open biceps tendinosis on 3/10/09 then, discovered infectin 2/13/13 requiring antibiotic spacer and IV antibiotics for 6 weeks, and left shoulder revision on 4/10/13.

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 of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Pool therapy:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Postsurgical Treatment Guidelines, which is part of the MTUS.

Rationale for the Decision:

At the time the physician requested the continuing pool therapy, the employee was still in the post-surgical physical medicine treatment period from the revision left shoulder surgery on 4/10/13. The post-surgical physical medicine treatment period is 6 months following 4/10/13. MTUS states "If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period." The employee was reported to have improved ROM although pain is severe, and motion is still limited. Flexion/abduction at 85 degrees currently, so it appears that additional functional improvement can be accomplished. The request appears to be in accordance with MTUS postsurgical treatment guidelines for the 6-month post-surgical physical medicine treatment period following the 4/10/13 surgery. The guideline criteria have been met. **The request for Pool therapy is medically necessary and appropriate.**

2) Regarding the request for Bilateral shoulder injections:

Section of the Medical Treatment Utilization Schedule 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, (2004), pg. 204, which is part of the MTUS, and the Official Disability Guidelines, shoulder Chapter, Steroid injections, which are not part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 9, shoulder, initial care, pg. 204, which is part of the MTUS.

Rationale for the Decision:

The records show the employee has decreased shoulder ROM and pain, left worse than right. The employee had the right shoulder subacromial injection on 7/25/13. There is no discussion of a left shoulder injection either being performed, or outcome. The records show that the right shoulder was already authorized. The 6/28/13 report that was available for UR to make a decision, was not available for IMR. There was no rationale and if the left shoulder was injected on 6/28/13, there was no assessment of outcome reported on the 7/25/13 report, which is available for IMR. The right shoulder injection on 7/25/13 appears in accordance with ACOEM criteria, but the rationale for the left shoulder is not discussed and the left shoulder injection cannot be confirmed to be in accordance with ACOEM without the rationale or access to the 6/28/13 report. Since the IMR request is for “bilateral” shoulders, and the necessity for the left shoulder injection is unknown, the request cannot be considered to be in accordance with ACOEM. **The request for Bilateral shoulder injections is not medically necessary and appropriate.**

3) Regarding the request for Theracords Pulley x2 :

Section of the Medical Treatment Utilization Schedule 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, (2004), pg. 299, and the Chronic Pain Medical Treatment Guidelines, Physical Medicine, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Exercise, pgs. 46-47, which is part of the MTUS, and the Official Disability Guidelines (ODG), which is not part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines recommend exercise, then states There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. This statement is made in the context of exercise for chronic pain. In this case, the employee has bilateral shoulder impingement, and had left shoulder surgery with complications and revision. The employee would have been in the post-surgical physical medicine treatment period. The exercises for postsurgical shoulder rehabilitation might be different then for exercises for general pain. The theraband shoulder pulleys are relatively inexpensive, ranging from \$12-\$25 online. One theraband pulley kit has the handles for both hands and can be used to rehab both shoulders. So the rationale for two of these is not clear to me. So while a point could be made for the one pulley to treat both shoulders, the need for the second unit appears to be redundant. There is not enough information provided to determine if the item is in accordance with any guideline. **The request for Theracords Pulley x2 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, 18th Floor
Oakland, CA 94612

/ldh

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.