

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/29/2013
Date of Injury: 2/25/2004
IMR Application Received: 8/7/2013
MAXIMUS Case Number: CM13-0008100

DEAR [REDACTED],

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: UPHOLD. This means we decided that none 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, [REDACTED]
/MCC

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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

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

The patient is a 56-year-old female who reported an injury on 02/25/2004. The patient underwent a right shoulder rotator cuff debridement and subacromial decompression on 02/25/2009. The patient also underwent a right shoulder bursectomy, synovectomy, lysis of adhesions, rotator cuff debridement, partial claviclectomy, Mumford procedure, rotator cuff repair, and insertion of pain pump catheter on 10/26/2011. The most recent imaging submitted for review was an MR arthrogram of the right shoulder on 05/16/2012 that revealed postsurgical changes with moderate to high grade articular-sided and intrasubstance tear of the infraspinatus tendon as well as a superior labral tear with associated paralabral cysts. The patient has complained of persistent right shoulder pain and functional limitations. On examination, the patient has tenderness to palpation and decreased range of motion with 90 degrees of flexion and 70 degrees of abduction. The patient also has positive impingement signs and 4/5 flexion and abduction strength. The patient was noted to have a diagnosis of right shoulder adhesive capsulitis. A note on 08/21/2013 reported that the patient's planned right shoulder surgery was cancelled as the anesthesiologist indicated that the patient had a heart attack, and they did not want to perform general anesthesia without cardiac clearance or a stress test. An EKG on 08/08/2013 revealed marked sinus bradycardia. The most recent note, signed on 10/07/2013, reported that the patient had continued right shoulder pain, and Dr. [REDACTED] was seeking evaluation and clearance for surgery.

IMR DECISION(S) AND RATIONALE(S)

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

1. Right Shoulder Diagnostic Arthroscopy, possible capsular release, manipulation under anesthesia, revision rotator cuff repair and revision biceps tenodesis is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, section on Shoulder (Acute & Chronic) which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 209-211, which is part of the MTUS

The Physician Reviewer's decision rationale:

ACOEM guidelines state "surgical considerations depend on the working or imaging-confirmed diagnosis of the presenting shoulder complaint." ACOEM guidelines also 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 patients with mild symptoms or those whose activities are not limited." The documentation submitted for review indicates that the employee has a history of 2 prior right shoulder surgeries. The most recent imaging study is approximately a year and a half old. The imaging study at that time did not reveal any significant pathology to warrant a capsular release, a revision rotator cuff repair or a revision biceps tenodesis. It appears that the employee has already been authorized for manipulation under anesthesia given the functional deficits of the right shoulder. ACOEM Guidelines recommend surgical consideration depending on imaging evidence. Given the lack of imaging evidence, the proposed surgical intervention for the right shoulder is not supported in its entirety. Furthermore, there is no indication that the employee has received cardiac clearance, as the anesthesiologist previously cancelled the surgery due to a history of cardiac issues. **The request for Right Shoulder Diagnostic Arthroscopy, possible capsular release, manipulation under anesthesia, revision rotator cuff repair and revision biceps tenodesis is not medically necessary and appropriate.**

2. Pre-op Labs/EKG is not medically necessary and appropriate.

The Claims Administrator based its decision on the National Collaborating Centre for Acute Care, Preoperative tests: the use of routine preoperative tests for elective surgery: evidence, methods & guidance, 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, Low Back Chapter.

The Physician Reviewer's decision rationale:

The Official Disability Guidelines recommend pre-operative labs and EKG studies for patients at high risk for complications with surgery. The medical records provided for review indicate that the employee's surgery had been cancelled by the anesthesiologist given the history of heart attack. Therefore, pre-operative workup would be warranted. However, the associated right shoulder surgical intervention was non-certified. Therefore, the request for pre-operative evaluation would likewise be non-certified. Furthermore, the employee underwent a recent EKG in 08/2013. Therefore, a repeat study would not be supported at this time. **The request for Pre-op Labs/EKG is not medically necessary and appropriate.**

3. Percocet Prescription 5/325mg #60 between 7/20/2013 and 9/20/2013 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines section on Opioids, pages 76-78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state that there should be "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The request for Percocet is for postoperative pain. However, the concurrent request for right shoulder surgery was found to be non-certified. Since the primary procedure is not medically necessary, none of the associated services are medically necessary. **The request for Percocet Prescription 5/325mg #60 between 7/20/2013 and 9/20/2013 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.

[REDACTED]

CM13-0008100