

Case Number:	CM13-0046824		
Date Assigned:	06/09/2014	Date of Injury:	04/11/2013
Decision Date:	07/29/2014	UR Denial Date:	10/25/2013
Priority:	Standard	Application Received:	11/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

This 64-year-old female sustained an industrial injury on 4/11/13 relative to a trip and fall. The right shoulder was dislocated. A closed reduction was performed in the emergency room. The 5/7/13 right shoulder MRI impression documented diffuse supraspinatus tendinosis and high-grade infraspinatus tear with possible full-thickness perforation. There was subscapularis tendinosis and delaminating intrasubstance tear. There was medial subluxation of the biceps tendon, glenohumeral joint degenerative change, and acromioclavicular (AC) joint osteoarthritis/hypertrophy with subacromial subdeltoid bursitis. The 10/25/13 utilization review denied the request for right shoulder surgery and associated services as the documentation did not meet guideline criteria for objective exam findings and conservative treatment was not fully evidenced. The 11/11/13 appeal letter stated the patient had been in physical therapy since the date of injury. She continued to be symptomatic and made small functional gains. Subjective complaints included intermittent mild right shoulder pain radiating to the biceps with instability, clicking and popping when lifting or carrying more than 8 pounds. Pain increased with reaching, moving the arm backwards, lifting above shoulder level, or lying on that side. Exam documented mild biceps tenderness and greater AC joint tenderness. Active range of motion testing documented abduction 90 and flexion 80. Passive range of motion was full. External rotation was 80 degrees. Apprehension, impingement and lift-off tests were positive. X-rays showed mild hypertrophy of the AC joint with type 2 acromion. The treating physician documented six months of non-surgical and conservative treatment that had been ineffective. Reconsideration of surgery and associated services/items was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPIC SUBACROMIAL DECOMPRESSION, MUMFORD PROCEDURE AND PROBABLE ROTATOR CUFF AND LABRAL REPAIR: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG (Shoulder Chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Acromioplasty, Partial Claviclectomy, Surgery for rotator cuff repair.

Decision rationale: The Official Disability Guidelines for rotator cuff repair and acromioplasty generally require 3 to 6 months of conservative treatment, and subjective, objective, and imaging clinical findings consistent with impingement. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. This patient presents with persistent pain with mechanical symptoms and functional limitations despite 6 months of comprehensive conservative treatment. Imaging findings are consistent with rotator cuff tear and acromioclavicular osteoarthritis. Clinical findings are consistent with impingement. Therefore, this request for right shoulder arthroscopic subacromial decompression, Mumford procedure, and probable rotator cuff and labral repair is medically necessary.

PAIN PUMP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Shoulder Chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Post-operative pain pump.

Decision rationale: The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request for pain pump purchase is not medically necessary.

MOTORIZED HOT/COLD FOR 30 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. A motorized hot/cold therapy unit was requested for 30 days use. Guidelines would support use for up to 7 days. There is no compelling reason presented to support the medical necessity of continuous flow cryotherapy is excess of guideline recommendations. Therefore, this request for motorized hot/cold therapy unit for 30 days rental is not medically necessary.

PRO SLING WITH ABDUCTION PILLOW: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Shoulder Chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a partial rotator cuff tear and arthroscopic repair is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request for Pro sling with abduction pillow is not medically necessary.

SPRIX 15.75 NASAL SPRAY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Sprix (ketorolac tromethamine nasal spray).

Decision rationale: The Official Disability Guidelines recommend ketorolac tromethamine (Sprix Nasal Spray) for the short-term management of moderate to moderately severe pain requiring analgesia at the opioid level. The total duration of use of this intranasal formulation, as with other ketorolac formulations, should be for the shortest duration possible and not exceed 5

days. The current request does not provide the specific duration of use being prescribed. Guidelines would support use not to exceed 5 days. There is no compelling reason presented to support the medical necessity of this medication beyond guideline recommendations. Therefore, this request for Sprix 15.75 nasal spray is not medically necessary.

RE-EVALUATION WITHIN 6 WEEKS: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Shoulder Chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Office visits.

Decision rationale: The Official Disability Guidelines recommend evaluation and management office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. Guideline criteria have been met. Routine follow-up orthopedic office visits during the post-operative period are consistent with guidelines. Therefore, this request for one re-evaluation within 6 weeks is medically necessary