

Case Number:	CM13-0072262		
Date Assigned:	01/10/2014	Date of Injury:	10/15/2013
Decision Date:	07/08/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	12/30/2013

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 Hand Surgery and is licensed to practice in Texas. 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:

The injured worker is a 61-year-old female who reported an injury on 10/15/2013. The injured worker reportedly collided with a parent at the school where she was teaching. Current diagnoses include full thickness rotator cuff tear and possible biceps tendon tear. The injured worker was evaluated on 11/18/2013. Previous conservative treatment includes muscle relaxants, analgesic medication, and physical therapy. The injured worker reports 7/10 pain. Physical examination revealed tenderness to palpation over the bicipital groove region, diffuse tenderness along the para-acromial region, pain and weakness with restricted abduction, positive impingement testing, and an absent biceps tendon tone. Treatment recommendations at that time included a rotator cuff repair. It is noted, the injured worker underwent an MRI of the right shoulder on 10/26/2013, which indicated moderate rotator cuff tendinosis with a non-acute, full thickness tear at the mid and anterior supraspinatus footprint yielding variable retraction of the tendon slip.

IMR ISSUES, DECISIONS AND RATIONALES

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

ROTATOR CUFF REPAIR WITH SUBACROMIAL DECOMPRESSION, RIGHT SHOULDER: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 209-210.

Decision rationale: CA MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs and clear clinical and imaging evidence of a lesion. Official Disability Guidelines state prior to a rotator cuff repair for a full thickness tear, there should be evidence of shoulder pain and an inability to elevate the arm with tenderness over the greater tuberosity in acute cases. There should also be documentation of weakness with abduction testing. There should be positive evidence of a deficit in the rotator cuff upon imaging studies. As per the documentation submitted, the injured worker does report persistent pain with an inability to utilize the upper extremity despite conservative treatment with medications, physical therapy, and TENS therapy. Physical examination does reveal painful provocative testing, pain and weakness with resisted abduction, positive impingement, and an absent biceps tone on the right. The injured worker's MRI of the right shoulder, obtained on 10/26/2013, does reveal a full thickness tear at the mid and anterior supraspinatus with retraction. Based on the clinical information received the injured worker does currently meet criteria for the requested surgical procedure. As such, the request is certified.

PAIN PUMP, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state postoperative pain pumps are not recommended. Moderate quality studies do not support the use of pain pumps. Therefore, the current request is not medically appropriate. As such, the request is not medically necessary.

INTERSCALENE BLOCK, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state interscalene block is recommended for specific indications. If a response to exercise is protracted, interscalene block has been reported to be efficacious in the relief of acute thoracic outlet syndrome, and as an adjunct to diagnosis. The injured worker does not maintain a diagnosis of thoracic outlet syndrome. Therefore, the current request is not medically appropriate. As such, the request is not medically necessary.

OFFICE VISIT FOR PRE-OPERATIVE MEDICAL CLEARANCE, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

PRE-OPERATIVE PROTHROMBLIN TIME, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

PRE-OPERATIVE COMPLETE BLOOD COUNT, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

PRE-OPERATIVE COMPREHENSIVE METABOLIC PANEL, RIGHT SHOULDER:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

PRE-OPERATIVE URINALYSIS, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

PRE-OPERATIVE ELECTROCARDIOGRAM, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative medical clearance. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

POST-OPERATIVE PHYSICAL THERAPY EVALUATION, RIGHT SHOULDER:
Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26-27.

Decision rationale: California MTUS Guidelines state the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery and postsurgical physical medicine treatment recommendations. Postsurgical treatment following rotator cuff repair includes 24 visits over 14 weeks. Given that the patient's surgical procedure has been authorized, the medical necessity for a postoperative physical therapy evaluation can be determined as medically appropriate. Therefore, the request is certified.

POST-OPERATIVE THERAPEUTIC EXERCISE, 3 TIMES WEEKLY, RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10, 26-27.

Decision rationale: California MTUS Guidelines state the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery and the postsurgical physical medicine treatment recommendations. Postsurgical treatment following rotator cuff repair includes 24 visits over 14 weeks. While the injured worker does meet criteria for the postoperative exercise, there is no quantity listed in the current request. Therefore, the request is not medically necessary.

POST-OPERATIVE MANUAL THERAPY, 3 TIMES WEEKLY, RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: CA MTUS Guidelines state manual therapy and manipulation is recommended if caused by a musculoskeletal condition. Treatment for the upper extremity is not recommended. Therefore, the current request cannot be determined as medically appropriate. There is also no quantity listed in the current request. As such, the request is not medically necessary.

PRE-OPERATIVE partial thromboplastin time, RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative Testing, General.

Decision rationale: Official Disability Guidelines state preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. There is no documentation of a significant medical history or comorbidities that would warrant the need for preoperative testing. As the medical necessity has not been established, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.