

Case Number:	CM14-0104658		
Date Assigned:	07/30/2014	Date of Injury:	02/01/2008
Decision Date:	09/11/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/07/2014

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 57-year-old female sustained an industrial injury on 2/1/08. The mechanism of injury was not documented. The patient underwent left shoulder arthroscopic debridement of a labral tear, subacromial decompression, subacromial bursectomy, anterior acromioplasty, and distal clavicle resection on 12/11/12 followed by 24 physical therapy visits. Records documented persistent left shoulder pain. The patient was examined on 12/16/13 and additional physical therapy was recommended. The patient failed to improve with physical therapy and was unable to lift her left arm. The 4/15/14 left shoulder MRI impression documented a full thickness supraspinatus tear measuring approximately 7 mm with no muscular retraction or atrophy. Findings included partial thickness infraspinatus tear, moderate acromioclavicular (AC) degenerative changes, minimal subacromial bursitis, and biceps tendinosis. The 5/22/14 orthopedic report indicated the patient had persistent left shoulder pain that was getting worse daily. Left shoulder exam findings documented swelling and subacromial, AC joint, and proximal biceps tenderness. Drop and impingement tests were positive on the left. Left shoulder range of motion was limited with flexion/abduction 150 degrees. Left shoulder strength was globally 3/5. The treatment plan recommended left shoulder arthroscopy including arthroscopic subacromial decompression, debridement, rotator cuff repair, Mumford procedure, platelet-rich plasma, AminoFix patch, and fascial sheath injection. Associated requests were submitted for pre-op services, post-op physical therapy, and durable medical equipment. The 6/11/14 utilization review denied the request for left shoulder platelet-rich plasma and AminoFix patch and fascial injection as there was no guideline support. Pre-operative testing requests were modified and approved to include history and physical, EKG, CBC, CMP, PT, PTT, and urinalysis. The chest x-ray was denied as this patient had no pulmonary comorbidities. The request for a post-op cold therapy unit was modified and approved for 7 day use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder platelet rich plasma and amniofis patch, fasical injection right forearm.:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Platelet- rich plasma (PRP) Other Medical Treatment Guideline or Medical Evidence: Anthem Medical Policy #SURG.00011 Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting, 4/15/14.

Decision rationale: The California MTUS does not provide recommendations for these requests. The Official Disability Guidelines state that platelet-rich plasma augmentation is an option in conjunction with arthroscopic repair for large or massive rotator cuff tears. Current medical policy guidelines state that AminoFix is considered investigational and not medically necessary for all uses. Only one RCT regarding its use has been published in the peer-reviewed published literature. However, due to the small study population and lack of investigator blinding, further research is warranted to fully understand the efficacy of this treatment method. Guideline criteria have not been met. There is limited support for the use of platelet-rich plasma in rotator cuff repair. The safety and efficacy of AminoFix for the current application has not been established. Therefore, this request for is not medically necessary.

Pre-operative clearance with history and physical.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pre-operative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. Middle-aged females have known occult increased medical/cardiac risk factors. Records indicate that this request was approved in the original utilization review modified decision. Given these clinical indications, this request for is medically necessary.

Pre-operative clearance with laboratory prothrombin time.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Low Back-Lumbar & thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have been met. The use of the requested pre-operative lab testing appears reasonable in a middle-aged female undergoing general anesthesia. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request for is medically necessary.

Preoperative clearance with electrocardiogram.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Preoperative testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. Middle-aged females have known occult increased cardiovascular risk factor to support the medical necessity of a pre-procedure EKG. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request is medically necessary.

Preoperative clearance urine testing.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Low Back-Lumbar & thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have been met. The use of the requested pre-operative lab testing appears reasonable in a middle-aged female undergoing general anesthesia. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request for is medically necessary.

Preoperative clearance laboratory test complete blood cell count.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Low Back-Lumbar & thoracic (Acute & Chronic).

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

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have been met. The use of the requested pre-operative lab testing appears reasonable in a middle-aged female undergoing general anesthesia. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request for is medically necessary.

Preoperative clearance laboratory test comprehensive metabolic panel.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Low Back-Lumbar & thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have been met. The use of the requested pre-operative lab testing appears reasonable in a middle-aged female undergoing general anesthesia. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request for is medically necessary.

Preoperative clearance laboratory partial thromboplastin time.: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Low Back-Lumbar & thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have been met. The use of the requested pre-operative lab testing appears reasonable in a middle-aged female undergoing general anesthesia. Records indicate that this request was approved in the original utilization review modified decision. Therefore, this request for is medically necessary.

Left shoulder post operative cold therapy unit.: 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) Shoulder, Continuous flow cryotherapy.

Decision rationale: The California MTUS are silent regarding cold therapy units. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery. Postoperative use generally may be up to 7 days, including home use. The 6/11/14 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

