

Case Number:	CM14-0134063		
Date Assigned:	08/27/2014	Date of Injury:	06/01/2013
Decision Date:	09/24/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/18/2014

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 is a 54 year old female with a 6/1/13 injury date. A mechanism of injury is not provided. The patient has a history of having frozen shoulder in the contralateral shoulder that was successfully treated with arthroscopy and lysis of adhesions (LOA). In a 7/9/14 follow-up, subjective complaints include 10/10 left shoulder pain. Objective findings include a very stiff shoulder, with limited active and passive range of motion. There is positive impingement sign and 4/5 strength in the rotator cuff. A left shoulder MRI on 7/1/14 showed supraspinatus tendinosis and small effusion. Diagnostic impression: left frozen shoulder. Treatment to date: self-directed exercise. A UR decision on 7/24/14 denied the request for left shoulder manipulation, subacromial decompression (SAD), lysis of adhesions (LOA), distal clavicle excision (DCE) and pain pump insertion on the basis that the procedure is not indicated based on current evidence-based guidelines. The request for pre-operative laboratory studies was denied because they are generally already included in the listed value for the surgical procedure. The request for chest xray was denied on the basis that the patient did not have signs or symptoms that would indicate medical necessity. The request for EKG was denied on the basis that it is generally only recommended for patients undergoing high-risk surgery or those undergoing intermediate-risk surgery who have additional risk factors. The request for pre-op medical clearance was denied on since the primary procedure was denied. The request for shoulder abduction pillow was denied since current guidelines only support their use after open repair of large and massive rotator cuff tears.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Left shoulder manipulation, subacromial decompression, lysis of adhesions, distal clavicle resection, and pain pump insertion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter.

Decision rationale: ODG criteria for manipulation under anesthesia include adhesive capsulitis refractory to conservative therapy lasting at least 3-6 months where abduction remains less than 90. CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. ODG criteria for arthroscopic release of shoulder adhesions include cases of adhesive capsulitis with failure of conservative treatment (physical therapy and NSAIDs). ODG supports partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. ODG does not recommend postoperative pain pumps, with 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. In the present case, there is no documented clinical or imaging evidence that the patient has AC joint pathology that would require distal clavicle excision. There is limited evidence that insertion of shoulder pain pumps is efficacious. With regard to shoulder manipulation and lysis of adhesions in the treatment of frozen shoulder, there is insufficient evidence that the patient has attempted at least 3-6 months of conservative treatment including formal physical therapy. With regard to subacromial decompression, there is also insufficient evidence that the patient has attempted prior conservative treatment which would include physical therapy and cortisone injection. Therefore, the request for Decision for 1 Left shoulder manipulation, subacromial decompression, lysis of adhesions, distal clavicle resection, and pain pump insertion is not medically necessary.

1 Pre-operative clearance/studies(history and physical, complete blood count (CBC), pregnancy serum test, Protime, partial thromboplastine time (PTT), basic metabolic panel): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, pages 92-93.

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: American Society of Anesthesiologists Practice Advisory for Preanesthesia Evaluation.

Decision rationale: CA MTUS does not address this issue. The American Society of Anesthesiologists states that routine preoperative tests (i.e., tests intended to discover a disease or disorder in an asymptomatic patient) do not make an important contribution to the process of perioperative assessment and management of the patient by the anesthesiologist; selective preoperative tests (i.e., tests ordered after consideration of specific information obtained from sources such as medical records, patient interview, physical examination, and the type or invasiveness of the planned procedure and anesthesia) may assist the anesthesiologist in making decisions about the process of perioperative assessment and management. In the present case, since the surgical procedures were not certified, the pre-op lab tests cannot be approved. Therefore, the request for Decision for 1 Pre-operative clearance/studies to include history and physical, complete blood count (CBC), pregnancy serum test, Prottime, partial thromboplastine time (PTT), basic metabolic panel (BMP) is not medically necessary.

Post-operative shoulder abduction pillow: 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 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 Chapter.

Decision rationale: CA MTUS does not address this issue. ODG recommends abduction pillow slings as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In the present case, the patient does not meet diagnostic criteria for the abduction pillow. Therefore, the request for post-operative shoulder abduction pillow is not medically necessary.

Pre-operative chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI).

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

Decision rationale: CA MTUS does not address this issue. ODG recommends chest X-Ray with acute cardiopulmonary findings by history/physical, or chronic cardiopulmonary disease in the elderly (> 65). Routine chest radiographs are not recommended in asymptomatic patients with unremarkable history and physical. In the present case, the surgical procedures were not certified. Therefore, the request for pre-operative chest xray is not medically necessary.

Pre-operative Electrocardiogram (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelinesm Low Back, Lumbar & Thoracic Chapters.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Lumbar & Thoracic Chapter.

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In the present case, the surgical procedures were not certified. Therefore, the request for pre-operative electrocardiogram (EKG) is not medically necessary.

Pre-operative medical clearance to include history and physical examination: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, pages 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Lumbar & Thoracic Chapter.

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In the present case, the surgical procedures were not certified. Therefore, the request for pre-operative medical clearance to include history and physical examination is not medically necessary.