MAXIMUS Federal Services

Case Number:	CM14-0054332		
Date Assigned:	08/08/2014	Date of Injury:	12/04/2013
Decision Date:	10/02/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/24/2014

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 Orthopaedic 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 49-year-old female customer service manager sustained an industrial injury on 12/4/13. Injury occurred when she picked up a bag of money weighing approximately 35 pounds and felt a pop and acute pain in the left shoulder. Past medical history was positive for hypertension and diabetes. Past surgical history was positive for multiple right shoulder surgeries with current active treatment. The 12/30/13 left shoulder MRI impression documented mild subscapularis tendinosis with no evidence of a tear, mild biceps tenosynovitis, and mild subcoracoid bursitis. There was degeneration of the labrum and suggestion of tear with scarring of the posterior labrum. There were mild acromioclavicular joint degenerative changes with mild to moderate synovitis and minimal subacromial bursitis. The 3/4/14 orthopedic report cited continued severe left shoulder pain. The bicipital tendon injection performed 2/4/14 was not helpful. Physical exam documented positive impingement, positive Hawkin's test, severe bicipital groove tenderness, positive apprehension sign, and weak external rotation. Range of motion testing documented forward elevation 95, abduction 90, internal rotation 70, and external rotation 80 degrees. Grip strength was decreased on the left. The diagnosis was left shoulder biceps tendinitis, probable degenerative labral tear, and impingement syndrome. The treatment plan requested authorization for left shoulder arthroscopic surgery as the patient had failed conservative treatment. The patient was not interested in another injection due to the severity of her pain. The patient was restricted to modified work. The 3/21/14 utilization review denied the surgical request as there was no evidence that the patient had failed a full course of guideline-recommended conservative treatment. The 4/1/14 orthopedic report cited continued severe left shoulder pain with positive findings consistent with impingement syndrome. She was having difficulty sleeping and pain was affecting her lifestyle. Physical therapy was completed for 12

visits without improvement. Medications and a local corticosteroid injection provided no improvement. Surgery was again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder subacromial decompression (SAD) debridement, possible labral repair: Overturned

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

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, Surgery for SLAP lesions

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For impingement syndrome, 3 to 6 months of conservative care, including steroid injections, is recommended prior to surgery. The Official Disability Guidelines provide specific criteria for surgery for SLAP lesions that includes 3 months of conservative treatment. History, physical exam, and imaging should be consistent with labral pathology. Guideline criteria have been met. This patient presents with persistent severe left shoulder pain and impingement signs that have not improved despite 4 months of guideline recommended conservative treatment. Imaging and clinical exam are consistent with a SLAP tear. Therefore, this request is medically necessary.

Seven day rental cold therapy unit: Overturned

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

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 devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option for up to 7 days after surgery. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. Guideline criteria have been met. Therefore, this request is medically necessary.

Seven day pain pump rental: Upheld

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

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

Decision rationale: The California MTUS guidelines are silent regarding this device. 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 is not medically necessary.

Continuous passive motion unit (CPM) rental for twenty one (21) days: Upheld

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

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 passive motion (CPM)

Decision rationale: The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in shoulder surgeries is not consistent with guidelines. Therefore, this request for is not medically necessary.

Purchase of one shoulder immobilizer: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Guideline criteria have been met. The use of a post-operative shoulder immobilizer is generally indicated. Therefore, this request is medically necessary.

Post-operative physical therapy to left shoulder three (3) times a week for eight (8) weeks consisting of one physical therapy eval and eighteen therapeutic exercise: Overturned

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

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy. Although this request exceeds recommendations for initial care, it is consistent with the recommended general course. Therefore, this request is medically necessary.

Outpatient medical clearance: Overturned

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

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 a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. Middle-aged diabetic females with hypertension have known occult increased medical/cardiac risk factors. Therefore, this request is medically necessary.

Electrocardiogram (EKG): Overturned

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

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 diabetic females with hypertension have known occult increased cardiovascular risk factor to support the medical necessity of a pre-procedure EKG. Therefore, this request is medically necessary.

Chest x-ray (CXR): Overturned

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

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: ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Middle-aged diabetic females with hypertension have known occult increased cardiac risk factors. Anesthesia is being administered in a lengthy procedure involving recumbency and significant fluid exchange. Therefore, this request is medically necessary.

Complete metabolic panel (CMP): Overturned

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

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 is reasonable given the patient's age and co-morbidities. Therefore, this request is medically necessary.

Complete blood count (CBC) with differential: Overturned

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

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 is reasonable given the patient's age and co-morbidities. Therefore, this request is medically necessary.

Prothrombin time (PT) with international normalized ratio (INR): Overturned

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

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 is reasonable given the patient's age and co-morbidities. Therefore, this request is medically necessary.

Partial thromboplastin time (PTT): Overturned

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

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 is reasonable given the patient's age and co-morbidities. Therefore, this request is medically necessary.

Routine urine culture: Overturned

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 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 is reasonable given the patient's age and co-morbidities. Therefore, this request is medically necessary.