

Case Number:	CM14-0068858		
Date Assigned:	08/11/2014	Date of Injury:	02/01/2010
Decision Date:	09/11/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/13/2014

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 61-year-old gentleman who sustained a vocational injury on 02/01/10. The claimant's current working diagnosis includes bilateral shoulder impingement syndrome right greater than left, partial to complete tear of the right rotator cuff with osteoarthritis of the acromioclavicular joint, cervical spine sprain and strain with discogenic disease. An MRI was obtained of the left shoulder on 08/23/10, which showed partial thickness tearing involving the supraspinatus tendon at its insertion, supraspinatus tendinitis, infraspinatus tendinitis, and intramuscular ganglion cyst within the subscapularis. The most recent office note available for review from 03/31/14 noted that the claimant had left greater than right shoulder pain, which was worse with use and better with rest. He was given a left shoulder corticosteroid injection, which provided about two weeks of relief. On examination of the left shoulder, there was tenderness over the acromioclavicular joint, tenderness over the biceps tendon/groove, tenderness over the suprascapular muscles, flexion to 100 degrees, abduction to 100 degrees, external rotation to 60 degrees and internal rotation to 50 degrees. The claimant was noted to have a positive impingement as well as Hawkins/Neer, positive thumbs down testing. Rotator muscle stressing is noted to be 5/5. The claimant has failed conservative treatment in regards to physical therapy, diagnostic Cortisone injection and oral medication. The current request is for a left shoulder diagnostic arthroscopy and decompression with possible Mumford procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder diagnostic arthroscopy and decompression with possible mumford procedure: Overturned

Claims Administrator 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter Diagnostic arthroscopy Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004) Partial claviculectomy (Mumford procedure) ODG Indications for Surgery -- Partial claviculectomy: Criteria for partial claviculectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint: 1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS 2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS 3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS 4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

Decision rationale: The California MTUS ACOEM Guidelines have been referenced. A previous utilization review determination have denied the request for left shoulder surgical intervention due to the fact that the MRI is greater than four years old. Currently, Official Disability Guidelines does not recommend repeat MRIs in the setting when pathology has already been established and is consistent with physical exam objective findings. Currently in this case, documentation presented for review suggests that based on subjective complaints and abnormal physical exam objective findings that the claimant has impingement syndrome as well as acromioclavicular joint pathology and symptoms. Diagnostic study performed in August of 2010 confirmed such pathology. The claimant has failed a reasonable course of conservative treatment. Furthermore, based on the documentation presented for review and in accordance with California MTUS ACOEM Guidelines and Official Disability Guidelines, the request for the surgical intervention in the form of a left shoulder diagnostic arthroscopy and decompression with possible Mumford procedure could be considered medically reasonable. Therefore, the request is medically necessary.

Pre-operative clearance: Overturned

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). Preoperative evaluation, Institute for Clinical Systems Improvement (ICSI); 2008 Jul. 32 p. (20 references)
http://www.guideline.gov/summary/summary.aspx?doc_id=12973&nbr=6682&ss=6&xi=999.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM Chapter 7, page 127.

Decision rationale: The claimant is 61 years of age and has some documented co morbidities. Prior to considering with surgical intervention, which would most likely involve general, anesthesia, it would be medically recommended to proceed with preoperative clearance based on California MTUS ACOEM Guidelines. The request is medically necessary.

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 (ODG): Shoulder Chapter, Continuous-flow cryotherapy.

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 Continuous Cold-Therapy Unit Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e., frostbite) are extremely rare but can be devastating. (Hubbard, 2004) (Osbaehr, 2002) (Singh, 2001).

Decision rationale: The California MTUS ACOEM Guidelines are silent and subsequently Official Disability Guidelines have been referenced. The Official Disability Guidelines support continuous cold therapy units following shoulder surgery for up to seven days, which includes home use in the postoperative setting. Subsequently, the request for the cold therapy unit can be approved for up to seven days following the requested surgical intervention, which has been considered medically necessary. Therefore, the request 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 Official Disability Guidelines (ODG): Shoulder Chapter, Pain Pumps.

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 Postoperative pain pump Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures. A surgeon will insert a temporary, easily removable catheter into the shoulder joint that is connected to an automatic pump filled with anesthetic solution. This "pain pump" was intended to help considerably with postoperative discomfort, and is removed by the patient or their family 2 or 3 days after surgery. 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. (Barber, 2002) (Quick, 2003) (Harvey, 2004) (Cigna, 2005) (Cho, 2007) Recent studies: Three recent RCTs did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. (Banerjee, 2008) This study concluded that infusion pumps did not significantly reduce pain levels. (Cicccone, 2008) This study found no difference between interscalene block versus continuous subacromial infusion of a local anesthetic with regard to efficacy, complication rate, or cost. (Webb, 2007) Adverse reactions: A small case series (10 patients) concluded that use of intra-articular pain pump catheters eluting bupivacaine with epinephrine appear highly associated with post-arthroscopic glenohumeral chondrolysis (PAGCL), and therefore intra-articular pain pump catheters should be avoided until further investigation. (Hansen, 2007) On the other hand, a retrospective study of 583 patients concluded that subacromial pain pumps used for arthroscopic shoulder procedures are safe in the short-term. (Busfield, 2008).

Decision rationale: California MTUS ACOEM Guidelines are silent and subsequently Official Disability Guidelines have been referenced. Currently, official Disability Guidelines do not support postoperative pain pumps as medically necessary. Subsequently, based on the documentation presented for review and in accordance with California MTUS ACOEM Guidelines and Official Disability Guidelines, the request for the postoperative pain pump cannot be considered medically necessary. Therefore, the request is not medically necessary.

Ultrasling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Immobilization.

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 Postoperative abduction pillow sling Recommended 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. (Ticker, 2008).

Decision rationale: The California MTUS ACOEM Guidelines are silent and subsequently Official Disability Guidelines have been referenced. Official Disability Guidelines support

postoperative abduction pillow slings such as an ultra sling medically reasonable only in a setting following open repair of large and/or massive rotator cuff repairs. Documentation presented for review and the request does not suggest that there will be involvement of a rotator cuff repair in light of the fact that documentation does not support that there is pathology consistent with large rotator cuff repair and subsequently the request for the ultra sling cannot be considered medically necessary.

Post operative Physical Therapy to the left shoulder, 12 visits: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California Postsurgical Rehabilitation Guidelines have been referenced. Currently, California Postsurgical Rehabilitation Guidelines support up to 24 visits over 14 weeks in a six-month period following surgical intervention in the form of impingement syndrome and partial clavectomy. Subsequently, the request for 12 visits coincides and falls well within the recommended guidelines following the requested surgical intervention and can be considered medically reasonable. Therefore, the request is medically necessary.