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| Case Number: | CM14-0071561 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 07/05/2013 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 04/14/2014 |
| Priority: | Standard | Application Received: | 05/17/2014 |

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 Indiana. 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 41-year-old male who suffered an injury to his right shoulder on 7/5/13. The worker strained his shoulder working on a machine and felt a popping/tearing sensation after the injury. The worker has a partial-thickness rotator cuff tear and AC degenerative changes and a probable superior glenoid labrum tear confirmed on MRI of the shoulder performed on 8/5/13. The worker complained of pain with lifting and abducting activities and had night pain. The worker's symptoms did not improve with PT and the worker declined corticosteroid injections. Clinically, on 3/13/14 the worker had 90 degrees of active forward flexion of the shoulder and 80 degrees of active abduction of the shoulder with 3/5 strength of both and tenderness over the bicipital groove and ac joint of the right shoulder. On 2/3/14, the worker had a positive Neer's and impingement test, positive Apley's, and positive Hawkin's tests. X-rays of the shoulder revealed sclerosis of the greater tuberosity and a calcific loose body and osteophytes of the ac joint. Diagnoses include right shoulder impingement syndrome, right shoulder subacromial bursitis, and an ac joint disorder. The injured worker has authorization for arthroscopic surgery on the right shoulder. The treating physician is requesting authorization for pre-operative testing including PFT, EKG, CXR, Interferential Current, Micro Cool, Home Exercise Kit, DVT Compression Pump and stockings, shoulder abduction brace, and post-op acupuncture for pain control 2x/week x 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pulmonary Function Testing (PFT): Upheld

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: Preoperative testing, general; Preoperative lab testing; Criteria for preoperative lab testing

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, Preoperative testing

Decision rationale: CA MTUS and ACOEM do not specifically address general preoperative testing. According to ODG, preoperative testing is helpful to stratify risk and is guided by the clinical history, co-morbidities, and physical examination findings. The injured worker has no history of respiratory problems, sleep apnea, or smoking history and at 41 years of age, there are no risk factors or co-morbidities that would necessitate a pre-operative PFT. For these reasons, the PFT is not medically necessary.

Chest X-Ray: Upheld

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: Preoperative testing, general

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, Pre-operative testing

Decision rationale: CA MTUS and ACOEM do not specifically address general preoperative testing. According to ODG, preoperative testing is helpful to stratify risk and is guided by the clinical history, co-morbidities, and physical examination findings. The injured worker has no history of respiratory problems, sleep apnea, or smoking history and at 41 years of age, there are no risk factors or co-morbidities that would necessitate a pre-operative PFT. For these reasons, the PFT is not 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, Low Back: Preoperative electrocardiogram (ECG), Criteria for Preoperative electrocardiogram (ECG)

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, Pre-operative testing

Decision rationale: CA MTUS and ACOEM do not specifically address general preoperative testing. According to ODG, preoperative testing is helpful to stratify risk and is guided by the clinical history, co-morbidities, and physical examination findings. The injured worker has no

history of cardiac disease, chest pain, hypertension, heart failure, peripheral vascular disease, or smoking history and at 41 years of age, there are no risk factors or co-morbidities that would necessitate a pre-operative EKG. However, the protocol at the hospital where the treating physician practices requires an EKG in patients over the age of 40 as outlined in the Presurgical Medical Clearance Consultation form included in the medical records provided for review. Therefore, following the treating hospital's protocol in order to allow the patient to be cleared medically for surgery, the requested EKG is medically necessary.

Interferential Current (IFC): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Interferential Current Stimulation Page(s): 118 - 120.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, ICS is not recommended as an isolated intervention and some insurance companies consider it experimental. It can be recommended if the pain is ineffectively controlled with medications, there are side effects of medications, history of substance abuse, inability to participate in exercise programs or PT, or unresponsiveness to conservative measures. Since the injured worker does not meet any of the criteria listed above for the use of ICS, the requested treatment is not medically necessary.

Micro Cool: 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: 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 (Acute and Chronic), Continuous-Flow Cryotherapy

Decision rationale: CA MTUS and ACOEM do not specifically address cold therapy. The ODG Guidelines for the shoulder do allow of up to 7 days of post-operative use of cold-flow cryotherapy units to decrease pain, inflammation, swelling, and narcotic usage. The treating physician has not requested a specific duration of treatment with the Micro Cool unit or whether it would be rented or purchased. Therefore, the requested Micro Cool unit is not medically necessary.

Home Exercise Kit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines do recommend exercise as part of treatment programs including strengthening and aerobic conditioning. No specific exercises are recommended over other exercises. Therefore, the requested Home Exercise Kit is considered medically necessary.

DVT Compression Pump and Stockings: 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: Venous thrombosis

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

Decision rationale: According to the ODG Guidelines for the shoulder, although it is generally believed that venous thromboembolism (VTE) after shoulder surgery is very rare, there are increasing reports of deep venous thrombosis (DVT) and pulmonary embolism (PE) associated with shoulder surgery. (Ojike, 2011) Deep vein thrombosis (DVT) has an incidence of 1 case per 1000 and it is very rare after arthroscopy of the shoulder. The administration of DVT prophylaxis is not generally recommended in shoulder arthroscopy procedures. For this reason, the requested DVT compression pump and stockings are not medically necessary. This is not specifically addressed in A MTUS.

Shoulder Abduction Brace: 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, Postoperative abduction pillow sling

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute and Chronic), Shoulder Abduction Pillow Sling

Decision rationale: CA MTUS is silent in regard to shoulder abduction braces. According to the ODG Guidelines, a shoulder abduction pillow sling is 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. For this reason, the requested Shoulder Abduction Brace is not medically necessary.

Post Operative Acupuncture two (2) times a week for six (6) weeks for Pain Control:
Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the CA MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Recommended frequency is 1 - 3 x/week for 1 - 2 months. The requested post-op acupuncture treatment 2x/week for 6 weeks for pain control fits within the allowed recommendations. Therefore, the requested acupuncture treatments are medically necessary.