

Case Number:	CM14-0083010		
Date Assigned:	07/21/2014	Date of Injury:	06/07/2012
Decision Date:	08/26/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/04/2014

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 47-year-old male sustained an industrial injury on 6/7/12, relative to repetitive upper extremity motions. Records indicate that the patient underwent conservative treatment including acupuncture, physical therapy, chiropractic, injections, medications and activity modification. Right shoulder injections provided on 4/24/13 on 5/13/13 provided 20-50% improvement for a few days, and then pain gradually returned. The 3/14/14 right shoulder MRI impression documented moderately severe reduction of the subacromial space and bursitis without evidence of rotator cuff tear or retraction. Findings documented mild acromioclavicular joint hypertrophic changes with narrowing and a mild indentation of the supraspinatus muscle. The 3/25/14 treating physician report cited recurrent right shoulder pain and night pain. Right shoulder range of motion testing documented forward flexion 0-175 degrees, external rotation 0-40 degrees, and internal rotation to T12. Painful arc of motion was reported from 90-140 degrees. The patient had a positive Hawkin's impingement sign with weakness in abduction testing. MRI showed type II acromion with subacromial bursitis. The diagnosis was right shoulder impingement syndrome. The treatment plan recommended right shoulder arthroscopy with subacromial decompression. The patient had six months of intermittent treatment aimed at strengthening and stretching. The 5/28/14 utilization review denied the request for right shoulder arthroscopy and associated requests based on an absence of guideline-recommended conservative treatment and clear clinical and imaging evidence of a surgical lesion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with subacromial decompression and medical clearance:

Overtured

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. 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. Imaging evidence and clinical exam findings are consistent with impingement syndrome. The patient has failed comprehensive conservative treatment, including steroid injections, for more than 6 months. Therefore, this request for right shoulder arthroscopy with subacromial decompression and medical clearance is medically necessary.

Post-op Physical Therapy two (2) times four (4): Overtured

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for subacromial decompression 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. Guideline criteria have been met. This is the initial request for post-op physical therapy and is within guideline recommendations for initial treatment. Therefore, this request for post-op physical therapy two (2) times four (4) is medically necessary.

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 devices. 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. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.

Deep Vein Thrombosis (DVT) Prophylactic compression cuffs: 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, Compression garments.

Decision rationale: The California MTUS are silent regarding deep vein thrombosis (DVT) prophylaxis. The Official Disability Guidelines do not recommend compression garments in the shoulder. Deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors. Guideline criteria have not been met. There were no significantly increased DVT risk factors identified for this patient. Therefore, this request for DVT prophylactic compression cuffs is not medically necessary.