

Case Number:	CM14-0088923		
Date Assigned:	07/23/2014	Date of Injury:	08/20/2012
Decision Date:	08/27/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	06/12/2014

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:

The patient is a 33 year old female who sustained an injury on 08/20/2012. The mechanism of injury is unknown. She underwent left shoulder arthroscopic extensive debridement of joint and superior labrum, anterior and posterior repair with arthroscopic acromioclavicular joint resection or Mumford on 02/11/2013. Prior treatment history included physical therapy, cortisone injection which offered temporary relief. Diagnostic studies reviewed revealed MRI of the left shoulder dated 11/13/2014 revealed subacromion bursitis with suspects capsulitis at the rotator interval manifested as increased signal intensity; normal appearance of the acromioclavicular joint and rotator cuff. Ortho note dated 03/18/2014 states the patient presented with complaints of right shoulder pain as a result of compensation but also has left shoulder pain as well. She reported stiffness in the neck and shoulder as well as limited range of motion bilaterally. On exam, the left shoulder revealed abduction is 60 degrees and on the right 110 degrees. The patient has tenderness along the rotator cuff and biceps tendon and mild tenderness along the AC joint. She has positive impingement on the left and mild on the right, positive Hawkins on the left and mildly positive on the right, and positive Speed test on the left and mildly positive on the right. The trapezius and shoulder girdle are tender bilaterally. Diagnoses are cervical sprain/strain with trigger points along trapezius and shoulder girdle on the left. The recommendation is left shoulder arthroscopic decompression and evaluation of labrum, biceps tendon, and rotator cuff surgery as well as preoperative clearance including CBC, EKG and chest x-ray and Polar care 21- day rental. Prior utilization review dated 05/13/2014 states the request for an EKG and Op Clearance Chest x-ray is denied as it is not medically necessary; Polar Care Immobilizer is medically necessary and therefore certified to reduce pain and swelling to protect the shoulder during the rehab period.

IMR ISSUES, DECISIONS AND RATIONALES

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

EKG: 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), Low Back, Preoperative electrocardiogram (ECG).

Decision rationale: The Official Disability Guidelines note the decision to order pre-operative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. The submitted documentation indicates the employee will undergo revision shoulder arthroscopy. However, there was no clinical evidence supplied for review to illustrate pre-existing conditions which would require pre-operative EKG and CXR. The patient is a healthy 33 y/o female with no medical comorbidities, and therefore the requested preoperative EKG is not medically necessary and appropriate.

Pre-Op Clearance Chest x-ray: 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), Low Back, Preoperative testing, general Other Medical Treatment Guideline or Medical Evidence: <http://www.choosingwisely.org/doctor-patient-lists/chest-x-rays-before-surgery/>.

Decision rationale: See response 1c. ODG does not support preoperative CXR in a healthy 33 y/o female with no medical comorbidities undergoing shoulder arthroscopy.

Polar Care Immobilizer: 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 ODG supports use of cryotherapy for up to 7 days for postoperative use as it has been shown to decrease pain, inflammation, swelling, and narcotic usage. The ODG does not support extended use to 21 days, therefore this request is not medically necessary.