

Case Number:	CM14-0194403		
Date Assigned:	12/02/2014	Date of Injury:	08/14/2013
Decision Date:	01/20/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/20/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 60-year-old female with date of injury of 08/14/2013. The listed diagnoses from the AME report from 05/20/2014 are: 1. Bilateral wrist radial styloid tenosynovitis, 2. Right elbow lateral epicondylitis, 3. Bilateral shoulder subacromial impingement, 4. Status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. Injections x2 from 2012 and 2013. According to this AME report, the patient complains of bilateral wrist and right shoulder pain. She mainly has weakness in the right hand which is constant. The left hand had similar problems but only about a third as much as the right. The examination shows left shoulder arthroscopic scars are well-healed. There is deltoid atrophy on the right. The patient complains of pain with range of motion testing. Tenderness was noted over the subacromial areas bilaterally. Impingement on 150 degrees of forward flexion on the right shoulder and 160 degrees of forward flexion on the left shoulder. The long head of the biceps are intact bilaterally. The documents include an AME report from 05/20/2014. The utilization review denied the request on 11/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder arthroscopy, SAD distal clavicle resection, synovectomy and rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 on Arthroscopy

Decision rationale: This patient presents with bilateral wrist and right shoulder pain. The patient is status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. The treater is requesting a RIGHT SHOULDER ARTHROSCOPY, SAD, DISTAL CLAVICLE RESECTION, SYNOVECTOMY, AND ROTATOR CUFF REPAIR. The MTUS and ACOEM Guidelines do not address this request; however, ODG Guidelines under the shoulder chapter for arthroplasty of the shoulder, states that it is recommended after 6 months of conservative treatment for selected patients. ODG's criteria include: glenohumeral and acromioclavicular joint osteoarthritis, posttraumatic arthritis, or rheumatoid arthritis with all of the following: severe pain or functional disability that interferes with activities of daily living or work; positive radiographic findings; conservative therapies have been tried for at least 6 months and failed, etc. The report making the request is missing to determine the rationale behind the request. The records do not show that the patient has had right shoulder arthroscopy in the past. In this case, the patient does not meet the criteria set forth by the ODG Guidelines for shoulder arthroscopy. The examination from the AME report does not show any significant symptoms that would warrant surgery. The request IS NOT medically necessary.

Pre-op clearance: 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 Chapter on Pre-Operative Testing, General

Decision rationale: This patient presents with bilateral wrist and right shoulder pain. The patient is status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. The treater is requesting a PREOP CLEARANCE. The MTUS and ACOEM Guidelines do not address this request. However, ODG under the Low Back Chapter on Preoperative Testing, general states, "Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status." In this case, the patient's shoulder surgery does not meet ODG's Guidelines and Pre-op clearance request IS NOT medically necessary.

Postoperative Therapy, eight sessions (2x4): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines postsurgical guidelines, shoulder Page(s): 26, 27.

Decision rationale: This patient presents with bilateral wrist and right shoulder pain. The patient is status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. The treater is requesting POSTOPERATIVE THERAPY, 8 SESSIONS (2X4). The MTUS postsurgical guidelines page 26 and 27 under arthroplasty recommends 24 visits over 10 weeks. It appears that the treater is making this request in conjunction with the request for a right shoulder arthroscopy. Given that the surgery has not met the guidelines, postoperative therapy is not warranted. The request IS NOT medically necessary.

DVT prophylactic compressions 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 chapter on Venous Thrombosis

Decision rationale: This patient presents with bilateral wrist and right shoulder pain. The patient is status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. The treater is requesting DVT PROPHYLACTIC COMPRESSION CUFFS. The MTUS and ACOEM Guidelines are silent with regards to this request; however, ODG Guidelines under the shoulder chapter on venous thrombosis states, "recommend monitoring risk of perioperative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment, and identifying subjects who are at high-risk of developing venous thrombosis and providing prophylactic measures such as consideration for anticoagulation therapy. ODG goes on to state that risk is lower in the shoulder compared to the knee and depends on: invasiveness of the surgery; postoperative mobilization period; use of central venous catheters, etc. The records do not show that the patient has used a DVT prophylactic compression cuff in the past. It appears that the treater is requesting this DVT unit following surgery. The report making the request is missing to determine the exact rationale for the request. Given that the patient's right shoulder arthroscopy did not meet the criteria per ODG Guidelines, the use of a DVT prophylactic compression cuff following surgery is not warranted. The request IS NOT medically necessary.

Q-tech cold therapy: 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 chapter on Continuous-Flow Cryotherapy

Decision rationale: This patient presents with bilateral wrist and right shoulder pain. The patient is status post left shoulder arthroscopy with subacromial decompression, rotator cuff repair from 08/16/2013. The treater is requesting a Q-TECH COLD THERAPY. The MTUS and ACOEM Guidelines are silent with regards to this request; however, ODG Guidelines on continuous-flow cryotherapy states that it is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. Given that the patient's right shoulder arthroscopy was denied, the request for a Q-tech cold therapy unit following surgery is not warranted. The request IS NOT medically necessary.