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| Case Number: | CM14-0207334 | | |
| Date Assigned: | 12/19/2014 | Date of Injury: | 03/16/1999 |
| Decision Date: | 03/04/2015 | UR Denial Date: | 11/17/2014 |
| Priority: | Standard | Application Received: | 12/11/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 patient is a 53-year-old female with a date of injury of 03/16/1999. According to progress report dated 10/13/2014, the patient presents with ongoing right shoulder pain, tenderness, stiffness, weakness, clicking and catching despite conservative treatments. Diagnostic study of the right shoulder obtained on 05/08/2014 revealed calcific supraspinatus tendinosis, subacromial bursitis, right acromioclavicular degenerative joint disease, and impingement syndrome. The patient has been advised that surgery is indicated. Physical examination revealed forward flexion 105 degrees, extension 40 degrees, abduction 140 degrees, adduction 40 degrees, and internal rotation 60 degrees on the right. The patient has severe supraspinatus tenderness on the right and moderate greater tuberosity tenderness. There is positive subacromial crepitus in the right. AC joint compression test of the right shoulder revealed positive impingement. The listed diagnosis is right shoulder subacromial impingement syndrome, acromioclavicular degenerative joint disease, and calcific tendinosis of the supraspinatus rotator cuff. The treating physician states that the patient is an excellent candidate for right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, and distal clavicular resection. It was noted surgery will be performed once authorization has been received. The request is for preoperative medical clearance, continuous passive motion therapy for 45 days, and Coolcare cold therapy unit for 90 days. The Utilization Review denied the request on 11/17/2014. Treatment reports from 06/04/2014 to 10/13/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre Operative Medical Clearance: Overturned

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 - Lumbar & Thoracic (Acute & Chronic) Chapter, Preoperative lab testing

Decision rationale: This patient presents with calcific supraspinatus tendinosis, subacromial bursitis, acromioclavicular degenerative joint disease, and impingement syndrome of the right shoulder. The current request is for preoperative medical clearance. With regards to medical clearance, ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings." "Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants." The Utilization Review letter dated 11/17/2014 approved the right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, and distal clavicular resection. The request for preoperative medical clearance was modified with the rationale that "preoperative medical clearance is to be performed by the surgeon as included in the global surgical fee. However, there is no documentation of any medical condition or medical necessity that will require an internal medical evaluation." ODG guidelines do support an evaluation to determine what is needed for pre-operative assessment. The request IS medically necessary.

Continuous Passive Motion CPM 45 Days: 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, continuous passive motion devices (CPM)

Decision rationale: This patient presents with calcific supraspinatus tendinosis, subacromial bursitis, acromioclavicular degenerative joint disease, and impingement syndrome of the right shoulder. The current request is for continuous passive motion (CPM), 45 days. The Utilization Review letter dated 11/17/2014 approved the right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, and distal clavicular resection. The ACOEM and MTUS do not discuss Continuous passive motion devices. Therefore, ODG guidelines were consulted. ODG under its shoulder chapter has the following regarding continuous passive motion devices (CPM), "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." ODG further states, "Rotator cuff tears: Not recommended after shoulder surgery or for nonsurgical treatment." In this case, the medical reports did not document adhesive capsulitis, for which CPM devices are indicated for. The patient does not meet the criteria provided by ODG for the use of a CPM device and there is no discussion regarding the medical necessity for its use. This request IS NOT medically necessary.

Cool-care Cold Therapy Unit, 90 Days: 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)

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-flow cryotherapy

Decision rationale: This patient presents with calcific supraspinatus tendinosis, subacromial bursitis, acromioclavicular degenerative joint disease, and impingement syndrome of the right shoulder. The current request is for Coolcare cold therapy unit, 90 days. The Utilization Review letter dated 11/17/2014 approved the right shoulder arthroscopic evaluation, arthroscopic subacromial decompression, and distal clavicular resection. The MTUS and ACOEM guidelines do not specifically discuss Vascutherm units. Therefore, ODG Guidelines are referenced. ODG Guidelines under the Shoulder chapter has the following regarding continuous-flow cryotherapy: "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 use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The MTUS Guideline recommends the duration of postoperative use of continuous-flow cryotherapy to be 7 days. In this case, the treating physician has recommended 90-days which exceeds what is allowed by ODG. This request IS NOT medically necessary.