

Case Number:	CM15-0000069		
Date Assigned:	01/09/2015	Date of Injury:	10/25/2010
Decision Date:	03/17/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/31/2014

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: New York
 Certification(s)/Specialty: Neurological Surgery

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 26 year old female clinical partner sustained an industrial injury on 10/25/2010 and developed chronic right shoulder pain following arthroscopic Bankart repair of anterior-inferior glenoid labrum articular disruption on 11/28/2011. She was off work for about a year and half receiving physical therapy. The diagnoses have included chronic joint pain in the right shoulder and right hand weakness and pain symptoms, etiology unclear and biceps tendinitis status post labral repair surgery. She underwent an ultrasound guided biceps tendon sheath injection on 12/24/2012 which gave her some relief. Acupuncture has been used and she takes oral pain medications, muscle relaxants and physical therapy. Currently, the injured worker (IW) complains of scapulothoracic and right sided neck pain. On examination on 07/16/2014, she had multidirectional shoulder instability and symptoms secondary to deconditioning, intertubercular groove region biceps tendinosis and scapulothoracic dyskinesis. The plan was to send her for aggressive strengthening in physical therapy, restrict lifting to less than 5 lbs., and get a MRI to definitively rule out internal derangement. On a visit of 11/13/2014, the IW was continuing to have right shoulder pain. Examination showed full range of motion with discomfort and tenderness to palpation. A MRI with contrast done 10/07/2014 showed sulcus of contrast at the chondrolabral junction anterior-inferior labrum appeared similar to slightly enlarged from the 08/10/2012 magnetic resonance arthrogram and may represent recurrent Perthes lesion. Synovitis in the biceps tendon sheath and subcoracoid recess was noted. Current medications include soma. The IW was given a return to work clearance with restrictions. On 12/08/2014 Utilization Review (UR) gave a modified approval of the request, certifying the right

shoulder arthroscopy, possible anterior labrum revision repair and open biceps tenodesis. Physical therapy was modified to twice a week for six weeks, and the pre-op medical clearance request of EKG, Chest X-ray, and labs of CBC, BMP, and PTT were modified to approve labs of CBC, BMP, PTT only. Post-operative durable medical equipment of Ultrasling, and a Cold therapy unit were modified to approve a cold therapy unit x7 day rental and a regular sling only. Official Disability Guide-Treatment in Worker's Compensation low back chapter addresses preoperative medical clearance of EKG and chest radiography.

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 Chapter

Decision rationale: According to the ODG guidelines for preoperative EKG addressed in the low back chapter, EKG would be recommended for those undergoing high risk surgery or those undergoing intermediate risk procedures who have associated cardiac risk factors. Documentation for this IW is not furnished which indicates her shoulder surgery is high risk. Documentation is not furnished which indicates she has any associated cardiac risk factors. Thus authorization for a pre-operative electrocardiogram (EKG) would be denied.

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 chapter

Decision rationale: Pre-operative chest radiography is also addressed in the Low back chapter. ODG guidelines would recommend that chest radiography would be indicated if it is expected that the post-operative or intra-operative management of the IW would be impacted by the knowledge gained from the x-ray. Documentation does not indicate there were any pulmonary problems in the IW's prior operative procedure or that there have been any pulmonary problems addressed in the frequent followup visits in the past two years. Physical examinations that are recorded do not contain evidence of red flags which would mandate a chest x-ray pre-operatively.

Post operative Ultrasling: 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

Decision rationale: A postoperative abduction shoulder sling is recommended as an option following open repair of large and massive rotator cuff repairs. The MR arthrogram in 2014 notes there are no massive rotator cuff tears. Documentation is not provided to explain the rationale of why the ultrasling is necessary. The proposed operation is not explained as requiring a large incision. Thus the ultrasling would be denied as not being 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 Chapter

Decision rationale: A continuous-flow cryotherapy unit is recommended as an option after surgery with use up to 7 days. Limitations on the use of such a unit are not provided in the documentation. Discussion in the Knee Chapter of the ODG guidelines indicates the scientific literature is insufficient to document the use of continuous-flow systems is associated with a benefit beyond convenience in the outpatient setting.