

Case Number:	CM15-0136810		
Date Assigned:	07/24/2015	Date of Injury:	01/10/2014
Decision Date:	08/21/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/14/2015

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, Indiana, Oregon
 Certification(s)/Specialty: Orthopedic 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:

The injured worker is a 43 year old female who sustained an industrial injury on 01/10/2014. Mechanism of injury occurred when she was throwing a heavy box to the top of a pallet and felt pain in the left shoulder. Diagnoses include other affections of the shoulder region, rotator cuff impingement syndrome, and osteoarthritis, unspecified whether generalized or localized involving the shoulder region. Treatment to date has included diagnostic studies, acupuncture, cortisone injections, and physical therapy. She is not working. She takes Advil for pain. On 05/05/2015 there is an unofficial Magnetic Resonance Imaging report of the left shoulder which showed evidence of a SLAP disruption, rotator cuff tendinosis with small partial interstitial tear at the superior subscapularis tendon insertion and fraying of the supraspinatus tendon, no evidence of a transmural tear. There is mildly type II acromion with moderate to severe acromioclavicular arthrosis. There is reactive marrow edema and spurring at the acromioclavicular joint with mild reactive fluid in the subacromial bursa. A physician progress note dated 06/24/2015 documents the injured worker complains of constant anteromedial pain in the left shoulder which she rates 8-10 out of 10. She has limited range of motion. On examination left shoulder active and passive range of motion forward flexion 120 degrees, abduction 70 degrees, external rotation is 30 degrees. There is tenderness over the acromioclavicular joint, Hawking's impingement sign is positive, Cross arm test is positive, and testing was difficult due to pain. Treatment requested is for left shoulder arthroscopy, subacromial decompression, Mumford, post op 14 day rental Game Ready unit, left shoulder, post op physical therapy, 12 visits, 2-3 times a week for 4 weeks, post op sling purchase, left shoulder, preoperative EKG, and preoperative labs (CBC, Chem 7).

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, subacromial decompression, Mumford: 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) shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the exam note from 6/24/15 demonstrates fulfillment of all criteria recommended. The request is medically necessary.

Preop labs (CBC, Chem 7): 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states: 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. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 43 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed arthroscopy (a low risk procedure). Therefore the request is not medically necessary.

Preop 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of preoperative clearance and testing. ODG, Low back, Preoperative testing general, is utilized. This chapter states that preoperative testing is guided by the patient's clinical history, comorbidities and physical examination findings. ODG states: 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. Preoperative ECG in patients without known risk factor for coronary artery disease, regardless of age, may not be necessary. CBC is recommended for surgeries with large anticipated blood loss. Creatinine is recommended for patient with renal failure. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate risk surgery who have additional risk factors. Patients undergoing low risk surgery do not require electrocardiography. Based on the information provided for review, there is no indication of any of these clinical scenarios present in this case. In this case the patient is a healthy 43 year old without comorbidities or physical examination findings concerning to warrant preoperative testing prior to the proposed arthroscopy (a low risk procedure). Therefore, the request is not medically necessary.

Post op sling purchase, left shoulder: Overturned

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): 212.

Decision rationale: According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case brief use after surgery is medically necessary.

Post op 14 day rental Game Ready unit, left shoulder: 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.

Decision rationale: CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for up to 7 days. In this case, the requested duration exceeds the guideline recommendations and the request is not medically necessary.

Post op physical therapy, 12 visits, 2-3 times a week for 4 weeks: Overturned

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): 26-27.

Decision rationale: Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, page 26-27 the recommended amount of postsurgical treatment visits allowable are: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months; The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. This request conforms to guidelines and is medically necessary.