

Case Number:	CM15-0053890		
Date Assigned:	03/27/2015	Date of Injury:	10/12/2014
Decision Date:	05/01/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	03/20/2015

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: Illinois, California, Texas
 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 52-year-old female with a reported date of injury of 10/12/14. Injury occurred when she slipped and fell, landing with her right arm out directly on her right side. Past medical history was reported as negative. Conservative treatment had included physical therapy, corticosteroid injection, anti-inflammatories, and opioid pain medication without sustained relief. The 11/5/14 right shoulder MRI impression documented an 11 mm anterior margin high-grade partial thickness, near full thickness, tear of the supraspinatus tendon on the background of moderate tendinosis. There was moderate superior fiber subscapularis tendinosis. There was subacromial/subdeltoid bursitis, which may indicate a non-visualized small component of full thickness supraspinatus tendon tearing. The 11/26/14 right shoulder x-rays documented acromioclavicular (AC) arthrosis. The 2/11/15 treating physician report cited grade 5/10 right shoulder pain that radiated down to the mid upper arm. Pain was worse in the morning and woke her up. Pain increased with overhead reaching and she reported weakness with over shoulder height activities. She had almost 100% temporary relief with a right shoulder corticosteroid injection, and improved range of motion with physical therapy, but persistent pain. Physical exam documented tenderness over the lateral acromion, and no instability. Passive range of motion was full. Active range of motion was limited to 80 degrees of flexion and abduction. Neer's, Hawkin's, and O'Brien's tests were positive. There was 4/5 biceps weakness. The diagnosis was right shoulder partial thickness rotator cuff tear and impingement/bursitis. Authorization was requested for right shoulder arthroscopy with subacromial decompression and rotator cuff repair. Associated surgical requests included cold compression therapy for 3 weeks

and pre-op studies to include chest x-ray, EKG, and labs (complete blood count, Chem 7, and coagulation studies: PT/PTT/INR). The 3/12/15 utilization review certified the request for right shoulder arthroscopy, subacromial decompression and rotator cuff repair along with pre-operative medical clearance. The request for pre-operative chest x-ray, EKG, and labs was modified to include EKG, complete blood count (CBC), and Chem 7 only. The request for compression therapy was non-certified as there were no risk factors for venous thrombosis identified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Preoperative tests: Chest X-ray, EKG and labs, including complete blood count (CBC), Chem 7, Prothrombin Time Blood Test (PT), Partial Thromboplastin time blood test (PTT), and International Normalized Ratio Blood test (INR): 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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Evidence based medical guidelines state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected based on history and physical examination. Guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. 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. 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. 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 3/12/15 utilization review partially certified this request to include an EKG, Chem 7, and complete blood count. There is no compelling reason presented by the treating physician or noted in the reviewed records to support the medical necessity of additional testing. There is no evidence of acute cardiopulmonary disease to support the medical necessity of chest x-ray. There is no history of bleeding, medical conditions that predispose her to bleeding, or documented use of anticoagulants to support the medical necessity of coagulation studies. A pre-operative medical clearance has been certified which will allow for exploration of additional indications for these tests. Therefore, this request is not medically necessary.

Compression therapy 3 times a week: 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: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Cold compression therapy.

Decision rationale: The California MTUS are silent regarding cold compression therapy. Cryotherapy is recommended using standard cold packs. The Official Disability Guidelines do not recommend cold compression therapy in for patients undergoing shoulder surgery. There is no evidence of improved clinical post-operative outcomes for patients using an active cooling and compression device over those using ice bags and elastic wrap after upper extremity surgery. There is no compelling reason in the records reviewed to support the medical necessity of a mechanical cold system over standard cold pack in the absence of demonstrated improved clinical efficacy. Therefore, this request is not medically necessary.