

Case Number:	CM14-0156507		
Date Assigned:	09/26/2014	Date of Injury:	02/10/2009
Decision Date:	03/25/2015	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/24/2014

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: 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:

This is a 70-year-old male with a 2/10/09 injury date. His left shoulder injury was from continuous cumulative trauma. In a 9/5/14 follow-up, subjective findings included left shoulder pain and weakness. Objective findings included tenderness to palpation over the acromioclavicular joint, sub acromial region, and trapezius muscle, positive impingement signs, positive cross-body adduction test, and grade 4/5 muscle weakness in flexion, external rotation, and abduction. A 9/16/14 rebuttal letter explains that the patient has had extensive conservative treatment of the left shoulder, including physical therapy, home exercise, activity modification, medications, and injections. In addition, left shoulder surgery was previously authorized on 1/14/13 but the patient did not meet medical clearance for the surgery and it did not go forward. At that time, it had been determined that the patient had completed sufficient conservative treatment which had not been beneficial. At this point, the patient has a new MRI, which shows progression of the pathology compared to a 2012 MRI. A 6/25/14 left shoulder MRI showed a supraspinatus partial thickness undersurface tear, acromioclavicular (AC) joint arthrosis, mild glenohumeral arthritis, biceps tenosynovitis, and a T2 hyperintense soft tissue mass just inferior to the subscapularis tendon and just medial to the humeral neck. Although this may represent a ganglion cyst, further characterization of this soft tissue mass with dedicated MRI with contrast study is recommended. The rebuttal letter also states in the 9/16/14 rebuttal letter that approval of the left shoulder MRI with contrast should be considered an extension of the approved request of the original MRI study obtained on 6/25/14 because the attending radiologist recommended it and it is needed for further clarification of the anatomy and diagnosis. Diagnostic impression:

left shoulder osteoarthritis, left shoulder impingement, AC joint arthritis, left shoulder soft tissue mass. Treatment to date: medications, activity modification, physical therapy, acupuncture, TENS unit, left shoulder injection (2010). A UR decision on 9/15/14 denied the requests for left shoulder arthroscopic decompression and distal clavicle resection on the basis that there was no documentation that all conservative therapy options have been exhausted. The request for MRI was denied because there was no significant change in exam since the previous MRI. The requests for pre-op clearance, post-op physical therapy, continuous passive motion (CPM), Surgi-stim unit, and post-op cold therapy unit were denied because the associated surgical procedures were not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. In this there appears to be sufficient evidence to reverse the prior UR decision. The patient has had an exhaustive conservative therapy protocol over the years that has included physical therapy, medications, and injections, and it appears unlikely that additional treatment of this sort will be of any benefit. In addition, the patient has already been certified for a similar left shoulder surgery in 2012, and this certification was based upon having completed appropriate conservative treatment and having the appropriate positive findings on physical exam and imaging studies. At this point, the pathology has worsened on his recent MRI compared to the 2012 MRI, and the patient continues to have weakness and impingement signs on exam. Therefore, the request for left shoulder arthroscopic decompression is medically necessary.

Distal clavicle resection left shoulder: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery, Partial Claviclectomy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder chapter--partial claviclectomy

Decision rationale: CA MTUS and ODG support partial claviclectomy (including Mumford procedure) with imaging evidence of significant AC joint degeneration along with physical findings (including focal tenderness at the AC joint, cross body adduction test, active compression test, and pain reproduced at the AC joint with the arm in maximal internal rotation may be the most sensitive tests), and pain relief obtained with an injection of anesthetic for diagnostic purposes. Non-surgical modalities includes at least 6 weeks of care directed towards symptom relief prior to surgery including anti-inflammatories and analgesics, local modalities such as moist heat, ice, or ultrasound. In this there appears to be sufficient evidence to reverse the prior UR decision. The patient has had an exhaustive conservative therapy protocol over the years that has included physical therapy, medications, and injections, and it appears unlikely that additional treatment of this sort will be of any benefit. In addition, the patient has already been certified for a similar left shoulder surgery in 2012, and this certification was based upon having completed appropriate conservative treatment and having the appropriate positive findings on physical exam and imaging studies. At this point, the pathology has worsened on his recent MRI compared to the 2012 MRI, and the patient continues to have tenderness over the AC joint and a positive cross-body adduction test on exam. Therefore, the request for distal clavicle resection left shoulder is medically necessary.

MRI scan dedicated up to the subscapularis to rule out tumor versus ganglion cyst:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--MRI

Decision rationale: CA MTUS criteria for imaging include emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; or clarification of the anatomy prior to an invasive procedure. In addition, ODG criteria for shoulder MRI include normal plain radiographs, shoulder pain, and suspected pathology likely to be demonstrated on MRI. In this case, the MRI with contrast is necessary to further evaluation the soft tissue mass noted in the previous MRI in June 2014. The attending radiologist has indicated that it is necessary for clarification of the anatomy and the diagnosis. In this instance, a change in physical exam would not be required in order to proceed with left shoulder MRI with contrast. Therefore, the request for MRI scan dedicated up to the subscapularis to rule out tumor versus ganglion cyst is medically necessary.

Pre-operative medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Pre-operative Testing

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--Pre operative EKG and Lab testing ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery

Decision rationale: CA MTUS does not address this issue. ODG states that pre-op testing 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. 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. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. The ACC/AHA 2007 Guidelines on perioperative cardiovascular evaluation and care for noncardiac surgery state that in the asymptomatic patient, a more extensive assessment of history and physical examination is warranted in those individuals 50 years of age or older. In this case, the patient is at least 70 years old and the associated surgical procedures have been certified. Therefore, the request for pre-operative medical clearance is medically necessary.

Post-operative physical therapy supervised rehab, left shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: CA MTUS allows for 24 physical therapy sessions over 14 weeks after arthroscopic subacromial decompression. Given that the associated procedures were certified, the request for post-op physical therapy is warranted. The physical therapy is approved for a maximum of 24 sessions occurring over the initial 14-week post-op period. Therefore, the request for post-operative physical therapy supervised rehab, left shoulder, is medically necessary.

Associated surgical services: Continuous passive motion (CPM), 45 day rental: 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), Shoulder Chapter

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--CPM

Decision rationale: CA MTUS does not address this issue. ODG does not consistently support the use of CPM in the postoperative management of rotator cuff tears; but CPM treatment for

adhesive capsulitis provides better response in pain reduction than conventional physical therapy. However, the patient does not have a diagnosis of adhesive capsulitis or evidence of significant loss of range of motion on exam. There is no rationale in the documentation to support the use of a CPM machine. Therefore, the request for continuous passive motion (CPM), 45 day rental, is not medically necessary.

Associated surgical service: Surgi-stim osteogenesis stimulator unit, 90 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Page(s): 116-1.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

Decision rationale: The SurgiStim unit incorporates interferential, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. Therefore, the request for Surgi-stim osteogenesis stimulator unit, 90 day rental, is not medically necessary.

Post-operative cold therapy unit: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter-- Continuous-flow cryotherapy

Decision rationale: CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, the surgical procedures were certified and the guidelines do support the use of a cold therapy unit in the first 7 days of the post-op period. A 7-day rental of a cold therapy unit can be approved. Therefore, the request for post-operative cold therapy unit is medically necessary.