MAXIMUS Federal Services

Case Number:	CM15-0015269		
Date Assigned:	02/03/2015	Date of Injury:	06/01/2012
Decision Date:	03/30/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/27/2015

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
Certification(s)/Specialty: Family Practice

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 57-year-old male, with a reported date of injury of 06/01/2012. The diagnoses include right shoulder tendonitis and impingement syndrome, right shoulder small rotator cuff tear, and right shoulder acromioclavicular joint arthrosis. Treatments have included physical therapy, an MRI of the right shoulder, a subacromial cortisone injection, and pain medications. The progress report dated 07/09/2014 indicates that the injured worker complained of discomfort in his right shoulder. It was noted that the injured worker completed eight sessions of physical therapy. He stated that there was no change in his symptoms. The physical examination showed tenderness to palpation of the anterior shoulder, mild tenderness to palpation in the acromioclavicular joint, mild weakness with isolation of the supraspinatus tendon with empty can maneuver. MRI of the right shoulder has shown supraspinatous tendinosis, infraspinatus tendinosis, and biceps tendinosis. On 12/31/2014, Utilization Review (UR) denied the request for right shoulder arthroscopy, subacromial decompression, distal clavicle resection, probable rotator cuff repair; preoperative labs - EKG, complete blood count (CBC), comprehensive metabolic panel (CMP), hemoglobin A1C; postoperative Percocet 5/325mg #60; postoperative physical therapy two times a week for twelve weeks; postoperative Arc 2.0 shoulder brace; and compression unit rental for twenty-one days. The UR physician indicated that there was no imaging study available indicating rotator cuff arthropathy or intra-articular pathology of the right shoulder, and since the requested surgery was denied the associated requests are also denied. The ACOEM Guidelines, the MTUS Postsurgical Guidelines, and the Non-MTUS Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy, Subacromial Decompression, Distal Clavicle Resection, Proable Rotator Cuff Repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-220.

Decision rationale: According to ACOEM Guidelines, "Shoulder surgery may be indicated for patients who have: 1. Red-flag conditions; 2. Activity limitations for more than four months, plus existence of a surgical lesion; 3. Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; 4. Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair." In this case, the injured worker has positive imaging studies and has failed conservative treatment including an injection. The request for Right Shoulder Arthroscopy, Subacromial Decompression, Distal Clavicle Resection, Proable Rotator Cuff Repair is medically necessary.

PRE EKG, CBC, CMP, Glucose, HGBA1C: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Preoperative Lab Testing

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Chapter, Preoperative testing, general

Decision rationale: According to the Official Disability Guidelines, preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. 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. The injured worker will be undergoing shoulder surgery, and the request for PRE EKG, CBC, CMP, Glucose, HGBA1C is medically necessary.

Post Percocet 5/325 #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: According to the MTUS guidelines, Percocet consists of Oxycodone and Acetaminophen and is a short acting opioid medication. The injured worker will be undergoing shoulder surgery, and the request for short term use of Percocet for postoperative pain is supported. The request for Post Percocet 5/325 #60 is medically necessary.

Post Physical Therapy 2X WK 12 WKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines,Postsurgical Treatment Guidelines.

Decision rationale: The MTUS Postsurgical Treatment Guidelines recommend an 'Initial course of therapy' which means 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. The injured worker will be undergoing shoulder surgery for which the guidelines recommend up to 24 visits of post operative physical therapy. While an initial 12 sessions is supported, the request for 24 sessions is not supported. Modification can not be rendered in this review. As such, the request for Post Physical Therapy 2X WK 12 WKS is not medically necessary.

Post OP ARC 2.0 Shoulder Bace: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder, Postoperative abduction pillow sling

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: According to ACOEM Guidelines, a sling may be warranted for AC joint strain or separation, or for acute pain in patients with rotator cuff tear. The injured worker is to undergo shoulder surgery, and the request for post operative immobilization is supported. The request for Post OP ARC 2.0 Shoulder Bace is medically necessary.

Cold Compression Unit Rental 21 Days With Vendor Recovery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder, Continuous-flow Cryotherapy

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

Decision rationale: According to the Official Disability Guidelines, 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 the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The request for 21 days rental of cold compression unit rental exceeds the recommended time frame for the use of this unit per referenced guidelines. Modification can not be rendered in this review. The request for Cold Compression Unit Rental 21 Days With Vendor Recovery is not medically necessary.