

<b>Case Number:</b>	CM15-0169923		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	04/19/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	07/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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: 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 40 year old female, who sustained an industrial-work injury on 4-19-14. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder acromioclavicular joint (AC) arthrosis, right shoulder partial thickness rotator cuff tear, right shoulder impingement and right shoulder strain. She has a medical history of hypertension and asthma. Medical records dated (5-20-15 to 7-15-15) indicate that the injured worker complains of neck pain and tightness and right shoulder pain that is worse with reaching up overhead, lifting and at night. She continues to have significant right shoulder pain and dysfunction. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 6-17-15 the injured worker has returned to work. The physical exam dated 7-15-15 reveals right shoulder flexion 175 degrees, abduction 175 degrees, external rotation is 80 degrees and internal rotation is 75 degrees. There is positive Speed's test and positive impingement. There is pain and weakness on resisted external rotation and abduction with the arm at the side. The physician recommended right shoulder arthroscopy surgery. The Magnetic Resonance Imaging (MRI) of the right shoulder dated 4-13-15 reveals acromioclavicular joint (AC) osteoarthritis with fluid within the joint space. There is tendinosis and partial thickness rotator cuff tear. Treatment to date has included pain medication, physical therapy, off of work, psychological sessions, acupuncture, diagnostics, pain management, right shoulder injection with transitory benefit, shockwave therapy and other modalities. The request for authorization date was 7-15-15 and requested services included Preoperative lab: PT-PTT, Preoperative lab: Electrolytes, Preoperative lab: Creatinine, Preoperative lab: Glucose, 12-18

Post-Op Physical Therapy Visits for the Right Shoulder, 2-3 times a week for 6 weeks, Associated Surgical Service: 1-2 Week Rental of Polar Care Unit, and Associated Surgical Service: Purchase of Sling with an Abduction Pillow. The original Utilization review dated 7-31-15 modified the request for Preoperative lab: PT-PTT, Preoperative lab: Electrolytes, Preoperative lab: Creatinine, Preoperative lab: Glucose, modified to include CMP, CBC, CXR and Electrocardiogram (EKG) only as there is no documentation of any coagulopathy or that she is on any anticoagulants and electrolytes, creatinine and glucose testing are included in the CMP. The request for 12-18 Post-Op Physical Therapy Visits for the Right Shoulder, 2-3 times a week for 6 weeks was modified to 12 post-operative physical therapy visits for the right shoulder as guidelines recommend up to 24 visits of physical therapy for arthroscopic rotator cuff surgery therefore modified to 12 visits. The request for Associated Surgical Service: 1-2 Week Rental of Polar Care Unit was modified to a 7 day rental of a cold therapy unit as guidelines recommend the use of cryotherapy unit for up to 7 days post-operative after shoulder surgery. The request for Associated Surgical Service: Purchase of Sling with an Abduction Pillow was modified to purchase of a sling only as the guidelines recommend the use of abduction pillow only if there is documentation of repair of a complete rotator cuff rupture and there is no evidence of this in the documentation.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Preoperative lab: PT/PTT:** 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); Low Back (updated 07/17/15) Online Version 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 (ODG) Low back, Preoperative testing.

**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. 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 40 year old without comorbidities or physical examination findings concerning to warrant preoperative PT, PTT prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Preoperative lab: Electrolytes: 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); Low Back (updated 07/17/15) Online Version 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 (ODG) Low back, Preoperative testing.

**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. 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 40 year old without comorbidities or physical examination findings concerning to warrant preoperative electrolytes prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Preoperative lab: Creatinine: 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); Low Back (updated 07/17/15) Online Version 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 (ODG) Low back, Preoperative testing.

**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. 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 40 year old without comorbidities or physical examination findings concerning to warrant preoperative creatinine prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**Preoperative lab: Glucose: 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); Low Back (updated 07/17/15) Online Version 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 (ODG) Low back, Preoperative testing.

**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. 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 40 year old without comorbidities or physical examination findings concerning to warrant preoperative glucose prior to the proposed surgical procedure. Therefore the request is not medically necessary.

**12-18 Post-Op Physical Therapy Visits for the Right Shoulder, 2-3x6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

**Decision rationale:** 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. In this case the requested range exceeds the 12 visits initially recommended. Therefore the request is not medically necessary.

**Associated Surgical Service: 1-2 Week Rental of Polar Care Unit: 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 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 (ODG) Shoulder, Continuous flow cryotherapy.

**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 upwards of 7 days. In this case the requested range exceeds the guidelines recommendation of 7 days. Therefore the request is not medically necessary.

**Associated Surgical Service: Purchase of Sling with an Abduction Pillow: 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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Abduction pillow.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG Shoulder section, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication for need for open rotator cuff repair and therefore the request is not medically necessary.