

Case Number:	CM15-0026617		
Date Assigned:	02/19/2015	Date of Injury:	01/13/2009
Decision Date:	04/02/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/11/2015

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 51-year-old female who sustained an industrial injury on 1/13/09. The mechanism of injury was noted as cumulative trauma. The 5/18/14 bilateral shoulder ultrasound study revealed acromioclavicular (AC) joint degenerative joint disease with subacromial impingement and rotator cuff tendinosis. The 11/21/14 orthopedic report indicated the patient had failed to improve with corticosteroid injections, medications and physical therapy. Right shoulder exam documented severe supraspinatus, moderate greater tuberosity, mild biceps tendon, and moderate AC joint tenderness. Range of motion was documented as flexion 130, extension 40, abduction 130, adduction 40, external rotation 90, and internal rotation 60 degrees. There was subacromial crepitus but no instability. There was 4/5 shoulder strength, and positive AC joint compression and impingement tests. The treatment plan recommended right shoulder arthroscopic evaluation, subacromial decompression, distal clavicle resection, and labral cuff debridement as indicated. Pre-operative clearance with sleep study was requested due to height and weight, and history of sleep apnea using a home CPAP. Additional post-op durable medical equipment was requested. The 1/20/15 utilization review indicated that the requested arthroscopic right shoulder evaluation, arthroscopic subacromial decompression, distal clavicle resection and labral and/or cuff debridement and supervised post-operative rehabilitative therapy, 3x4 had been certified. The requested pre-operative medical clearance, along with a home sleep study was modified to a pre-operative medical clearance (not including home sleep study). The request for home continuous passive motion (CPM) device, initial period of forty five days, was non-certified. The requested Surgi-Stim unit, initial period of 90 days was modified to 30 day

rental of simple transcutaneous electrical nerve stimulation (TENS) unit. The requested Cool care cold therapy unit was certified to 7 day rental of simple continuous flow cold therapy unit. ACOEM; CA MTUS and Official Disability Guidelines were used in the utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated Surgical Services: Pre operative medical clearance, along with a home sleep study: 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) Pain (Chronic), Polysomnography and Other Medical Treatment Guidelines 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 these services. Evidence based medical guidelines indicate that most pre-operative testing is 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. The Official Disability Guidelines recommend polysomnography (sleep study) after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. The 1/20/15 utilization review modified the request for preoperative medical clearance, along with a home sleep study, to a preoperative medical clearance without sleep study. Guideline criteria have not been met for inclusion of the sleep study. There are no specific parameters of sleep dysfunction documented. CPAP use is currently reported suggesting a prior work-up with no rationale to support additional testing. There is no compelling reason to support the medical necessity of preoperative medical clearance beyond that already certified. Therefore, this request is not medically necessary.

Associated Surgical Services: Surgi-Stim unit, initial period of 90 days: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the

treatment of chronic pain, as this unit is primarily part of rehabilitation program following stroke. Guidelines indicate that galvanic stimulation is not recommended and considered experimental for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Guidelines indicate that TENS may also be an option for acute post-operative pain in the first 30 days after surgery. The 1/20/15 utilization review indicated that the request for a Surgi-Stim unit was modified to 30 day rental of simple transcutaneous electrical nerve stimulation (TENS) unit. There is no compelling reason to support the medical necessity of this request in the absence of guideline support and beyond the TENS unit currently certified. Therefore, this request is not medically necessary.

Associated Surgical Services: Coolcare cold therapy unit: 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: Continuous flow cryotherapy.

Decision rationale: The California MTUS is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following knee surgery. The 1/20/15 utilization review decision modified the request for a Cool care cold therapy unit to 7 day rental of simple continuous flow cold therapy unit. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

Associated Surgical Services: Home continuous passive motion (CPM) device, initial period of forty five days: 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 Shoulder: Continuous passive motion (CPM).

Decision rationale: The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in shoulder surgeries is not consistent with guidelines. Therefore, this request is not medically necessary.