

Case Number:	CM15-0048836		
Date Assigned:	04/15/2015	Date of Injury:	04/26/2011
Decision Date:	06/02/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/16/2015

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, Sports Medicine

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 34 year old male, who sustained an industrial injury on April 26, 2011. The injured worker reportedly felt an immediate pop in the right shoulder while working with a motorized pallet jack. The injured worker was diagnosed as having a right rotator cuff tear. Treatment to date has included rotator cuff repair, physical therapy, imaging of the right shoulder and medications. The latest physician progress note submitted for this review is documented on 01/15/2015. The injured worker presented for an initial orthopedic consultation with complaints of persistent right shoulder pain. It was noted that the injured worker was approximately 12 months status post rotator cuff repair. The injured worker noted an initial improvement in symptoms over the last 12 months. The injured worker has completed a course of physical therapy; however, continues to have cracking and snapping sensation as well as pain with an inability to return to work. The injured worker presented for further care and evaluation. The injured worker also reported numbness and tingling in the 4th and 5th finger on the right hand with increasing discomfort in the left shoulder due to overusing the left upper extremity. Upon examination of the left shoulder, there was 160 degree forward flexion, 150 degree abduction, 60 degree external rotation, and positive impingement sign. Examination of the right shoulder revealed 140 degree forward flexion, 120 degree abduction, 45 degree external rotation, and positive impingement sign. There was discomfort and weakness with isolated supraspinatus testing as well as Speed's testing. There was also tenderness noted along the bicipital groove with mild crepitus on range of motion. A recent MRI of the right shoulder obtained on 01/22/2014, reportedly revealed normal findings. Treatment recommendations at that time

included a tesla MRI of the right shoulder to gage the status of the prior rotator cuff repair and any recurrent tearing. The injured worker was to continue with rest and modified activities. It was also noted that the injured worker may be a candidate for an EMG/NCV evaluation of the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pre-op medical clearance; CMP, PT, PTT, CBC, UA, EKG, chest x-ray: 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) Low Back Chapter, Preoperative testing, general.

Decision rationale: According to the Official Disability Guidelines, the decision to order preoperative testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, the injured worker was pending authorization for a right shoulder revision arthroscopy. There was no documentation of a significant medical history or any underlying comorbidities to support the necessity for preoperative testing. As the medical necessity has not been established, the request is not medically necessary at this time.

Associated surgical service: Shoulder immobilizer: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Postoperative abduction pillow sling.

Decision rationale: According to the Official Disability Guidelines, a postoperative abduction pillow sling is recommended as an option following an open repair of a large or massive rotator cuff tear. Abduction pillows are not recommended for arthroscopic repairs. In this case, the injured worker was pending authorization for a right shoulder revision arthroscopy. There was no documentation of a massive or large rotator cuff tear. As the medical necessity has not been established, the request is not medically necessary at this time.

Associated surgical service: Cold therapy 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.

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, Continuous flow cryotherapy.

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy for up to 7 days following surgery. In this case, the injured worker was pending authorization for a right shoulder revision arthroscopy. However, the request for a cold therapy unit purchase exceeds guideline recommendations. As such, the request is not medically necessary.

Associated surgical service: Arm sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Postoperative abduction pillow sling.

Decision rationale: According to the Official Disability Guidelines, a postoperative abduction pillow sling is recommended as an option following an open repair of a large or massive rotator cuff tear. Abduction pillows are not recommended for arthroscopic repairs. In this case, the injured worker was pending authorization for a right shoulder revision arthroscopy. There was no documentation of a massive or large rotator cuff tear. As the medical necessity has not been established, the request is not medically necessary at this time.

Associated surgical service: DVT machine rental with cuffs purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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, Venous Thrombosis.

Decision rationale: The Official Disability Guidelines recommend monitoring the risk of perioperative thromboembolic complications in the acute and subacute postoperative period for possible treatment and identifying subjects who are at a high risk of developing a venous thrombosis. It is recommended to treat patients of asymptomatic mild upper extremity DVT with anticoagulation alone and patients of severe or extensive upper extremity DVT with a motorized mechanical device. In this case, the injured worker was pending authorization for a right shoulder revision arthroscopy. There was no indication that the injured worker was at high risk of developing an upper extremity DVT. There was also no mention of a contraindication to oral anticoagulation as opposed to a motorized mechanical device. Given the above, the request is not medically necessary at this time.

Post-op aquatic therapy 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: The California MTUS Guidelines recommend aquatic therapy as an optional form of exercise therapy, where available as an alternative to land based physical therapy. Aquatic therapy is recommended where reduced weight bearing is desirable. In this case, there was no indication that the injured worker required reduced weight bearing. There was no mention of a contraindication to land based physical therapy as opposed to aquatic therapy. In addition, the request as submitted failed to indicate the specific body part to be treated. Given the above, the request is not medically necessary.