

Case Number:	CM15-0072993		
Date Assigned:	04/23/2015	Date of Injury:	04/22/2013
Decision Date:	06/29/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/16/2015

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: 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 47-year-old female who sustained an industrial injury on 4/22/13. Injury was reported due to cumulative trauma relative to her employment as a customer service representative. Past medical history was positive for hypertension. The injured worker was diagnosed with bilateral carpal tunnel syndrome, right medial and lateral epicondylitis, right shoulder bursitis and impingement, right shoulder rotator cuff tendinosis and bursitis, and partial tear right elbow common extensor tendon tear and tendinitis. The 11/7/13 right shoulder MRI impression documented moderate rotator cuff tendinosis with subacromial subdeltoid bursitis and acromioclavicular (AC) joint degenerative change without full thickness tear or retraction. There was no evidence for acute labral or osseous abnormality. There was subcoracoid bursitis. Findings documented a type II acromion with lateral downsloping and moderate AC joint degenerative change. Conservative treatment was reported to include anti-inflammatory medications, topical creams, activity modification, physical therapy, and home exercise program. The 3/11/15 treating physician report cited constant grade 6-7/10 shoulder pain, right greater than left. Pain increased with any lifting and especially with overhead activities. She reported limitation in activities of daily living. She had completed 24 visits of physiotherapy that helped with pain, and a right shoulder corticosteroid injection with 30-40% relief for about one week. She was using Lidopro cream and anti-inflammatory medications. Right shoulder exam documented decreased active range of motion with flexion 130 degrees and abduction 130 degrees. There was tenderness to palpation over the AC joint. There was no instability on shoulder exam. Neer's, Hawkin's, and O'Brien's tests were positive. There was 5-/5 internal and external rotator, biceps, and deltoid strength. Imaging was reviewed. The diagnosis included right shoulder bursitis and impingement, and AC arthrosis. The treatment

plan recommended right shoulder arthroscopy with subacromial decompression and distal clavicle resection. Work restrictions included limited lifting. The 4/1/15 utilization review non-certified the request for right shoulder arthroscopy with subacromial decompression and distal clavicle resection and associated pre-operative services as there was no imaging documentation of impingement or evidence of 3-6 months of conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Arthroscopy with Subacromial Decompression and Distal Clavicle Resection: Overturned

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

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: Surgery for Impingement syndrome; Partial claviclectomy.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging evidence of positive evidence of impingement. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been essentially met. This injured worker presents with persistent and function-limiting right shoulder pain. Clinical exam findings are consistent with imaging evidence of AC joint arthrosis and plausible impingement. There was a positive diagnostic injection test documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-Op 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative Evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient's age, the magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Pre-Op Studies (CBC, Chem-7, Partial Prothrombin Time, Prothrombin Time, International Normalized Ratio): Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are 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. Guideline criteria have been met based on patient's age, comorbidity, long-term non-steroidal anti-inflammatory drug use, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Chest X-Ray and EKG: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 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 this service. Evidence based medical guidelines state that EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Middle-aged females with hypertension have known occult increased medical/cardiac risk factors that support the medical necessity of pre-procedure EKG and chest x-ray. Therefore, this request is medically necessary.