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| <b>Case Number:</b>   | CM13-0000454 |                              |            |
| <b>Date Assigned:</b> | 03/03/2014   | <b>Date of Injury:</b>       | 02/21/2013 |
| <b>Decision Date:</b> | 04/04/2014   | <b>UR Denial Date:</b>       | 05/03/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/22/2013 |

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 31-year-old male claimant who sustained a left shoulder injury on 12/7/2012 when he was attacked by a student. The claimant's diagnosis was left shoulder high grade partial thickness tear of supraspinatus portion of rotator cuff; left shoulder superior and posterior labral tear. Conservative care to date was documented in the 4/30/2013 office visit note as a left shoulder cortisone injection that helped for only one week; physical therapy, activity restrictions; Norco; Ketoprofen. The 3/6/2013 MRI of the left shoulder report revealed an obliquely oriented high grade partial thickness intrasubstance tear of the central and anterior fibers of the supraspinatus tendon with concomitant mild to moderate supraspinatus tendinitis; a suspected superior and posterior labral tear from approximately 9:00 to 11:00 position; mild acromioclavicular joint osteoarthritis. The report findings revealed an acromion with a type III configuration with mild subacromial/subdeltoid bursitis. The 6/10/2013 [REDACTED] office visit note stated that the claimant reported continued left shoulder pain. The claimant completed 16 physical therapy sessions with no sustained relief reported. He reported that the medications were no longer helping. He reported that he had constant pain at night with sleep disturbances. His left shoulder flexion was 90 degrees; abduction 80 degrees; extension 35 degrees; internal rotation 70 degrees; external rotation 75 degrees and pain with range of motion. The plan was continue medications and surgical intervention; modified work duties and activity modifications. The request is for left shoulder arthroscopy with rotator cuff repair, labral repair and Mumford procedure; pain pump 4 day rental; cold unit 14 day rental; interferential unit 30 day rental; continuous passive motion unit 30 day rental unit; Prilosec 20mg #60; Capsaicin #1. These requests were previously reviewed and non-certified by [REDACTED] on 5/7/2013 because surgery was not indicated for patients with mild symptoms or those whose activities are not limited; there was no documentation demonstrating a 3 month failure of conservative care. Regarding the requests for

a pain pump, cold therapy unit rental, interferential unit rental, sling, post surgical physical therapy and a continuous passive motion unit, the concomitant request for surgery has been non-certified therefore these requests are subsequently non certified. Prilosec was not indicated because the claimant does not have a history of GI complaints. Ketoprofen is not approved as a topical application.

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

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

### **1 Left Shoulder Arthroscopy with Rotator Cuff Repair, Labral Repair and Mumford Procedure: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp, 18th edition, 2013 Updates, Chapter: Shoulder, Indication for Surgery.

**Decision rationale:** The request is for left shoulder arthroscopic rotator cuff repair, labral repair, and distal clavicle excision. This 33-year-old was injured a year ago, December 7, 2012. The diagnosis was that of a high-grade partial-thickness rotator cuff tear. The claimant had an injection with short-term but not lasting benefit, therapy, activity modification, and anti-inflammatory agents. An MRI was felt to show a high-grade partial-thickness tear. In light of the ongoing symptoms, the procedure would be appropriate. The claimant has had a year long history of pain and has failed to respond to conservative treatment. At this point in the claimant's treatment the request for left shoulder arthroscopy with rotator cuff repair, labral repair and Mumford procedure is recommended as medically necessary.

### **1 Pain Pump 4 day Rental: 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 (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013.

**Decision rationale:** The CA MTUS Guidelines are silent. Based upon the Official Disability Guidelines, the request for a pain pump would not be supported post-surgically. ODG states that there is a lack of evidence to support that the use of a pain pump is as effective or more effective than the use of conventional postoperative pain control by oral, intramuscular, or intravenous medications.

### **1 Cold Unit 14 day Rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013 Updates, Chapter: Shoulder, Continuous flow cryotherapy

**Decision rationale:** The CA MTUS Guidelines are silent. Based upon the Official Disability Guidelines, the request for rental of a cold unit for 14 days cannot be recommended as medically necessary. The rental of the cold therapy unit is requested for 14 days which would exceed the 7 day rental recommended by the Official Disability Guidelines.

**1 IF Unit 30 day Rental:** 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 (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** Based upon the ACOEM 2004 Guidelines, there is no justification for an interferential unit following surgery. There is no documentation to support that the claimant has significant postoperative pain that is not controlled by other conservative measures or that he is unable to participate in his rehab program.

**1 CPM 30 day Rental 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 (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Worker's Comp 18th edition, 2013 Updates, Chapter: Shoulder, Continuous passive motion (CPM):

**Decision rationale:** A 30 day rental of a continuous passive motion (CPM) machine following a shoulder rotator cuff repair based upon the Official Disability Guidelines recommendation that it is not used for rotator cuff problems.

**1 Prescription of Prilosec 20mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Worker's Comp 18th edition, 2013 Updates, Chapter: Integrated Treatment/Disability Duration Guidelines, Appendix A ODG Workers' Compensation Drug Formulary, Proton pump inhibitors (PPIs):

**Decision rationale:** Based upon the CA MTUS Chronic Pain 2009 Guidelines and supported by the Official Disability Guidelines, the use of Prilosec is not indicated. The CA MTUS Chronic Pain Guidelines only recommend the use of Prilosec for patients greater than age 65 years old, with a history of peptic ulcer, GI bleeding, or perforation, concurrently using ASA, corticosteroids, and/or anticoagulant, or on high dose/multiple NSAIDS. The claimant is 31 years old and the medical records provided for review do not contain any documentation of gastrointestinal (GI) history, use of ASA, corticosteroids, or anticoagulants.

**1 Prescription of Capsaicin #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, topical Page(s): 28-29.

**Decision rationale:** Based upon the CA MTUS Chronic Pain 2009 Guidelines, Capsaicin would not be indicated following surgery. Capsaicin is only recommended for use by the MTUS Chronic Pain Guidelines for patients who are intolerant or have not responded to other forms of treatment. There is no documentation within the records reviewed to indicate that the claimant is intolerant or has not responded to other forms of treatment.