

Case Number:	CM13-0004025		
Date Assigned:	12/11/2013	Date of Injury:	02/12/2001
Decision Date:	02/10/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	07/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

The patient is a 50-year-old gentleman who was injured on 02/12/01. Specific to the claimant's right shoulder, there is documentation of a 07/15/13 assessment with [REDACTED], indicating continued complaints of pain about the shoulder stating an inability to raise the shoulder above overhead level with physical examination showing forward flexion to 180 degrees with positive abduction, tenderness, positive impingement, and tenderness to palpation over the anterior aspect of the shoulder. The claimant at that time was diagnosed with right shoulder impingement and osteoarthritis. Based on the longstanding failed conservative care that had included anti-inflammatory agents, corticosteroid injections, and activity modification, a right shoulder arthroscopy, decompression with rotator cuff and SLAP repair, open biceps tenodesis and a distal clavicle excision was recommended. Prior treatment to the upper extremity also includes a previous right lateral epicondylar release to the elbow in 2009 as well a right carpal tunnel release procedure in April of 2011, as well as a second lateral and medial epicondylar release to the elbow in January of 2013. The clinical imaging in regard to the claimant's shoulder is not formally available, but it is documented that there is AC joint hypertrophy with impingement of the supraspinatus and partial thickness tearing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for one (1) right shoulder arthroscopy, subacromial decompression, possible rotator cuff repair, possible SLAP repair, possible open biceps tenodesis, excision distal clavicle between 7/17/2013 and 8/31/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure - Surgery for ruptured biceps tendon (at the shoulder).

Decision rationale: Based on California MTUS Guidelines and supported by Official Disability Guidelines criteria, the surgical process would not be supported. The records in this case do not indicate full thickness rotator cuff tearing or SLAP tearing that would necessitate the role of SLAP or rotator cuff repair. There is also no indication of bicipital findings on examination or imaging to support the role of tenodesis. While the claimant continues to be symptomatic with impingement symptoms, the specific surgical request which would include rotator cuff, labral, and bicipital processes would not be indicated

Request for one (1) stable abduction sling between 7/17/2013 and 8/31/20: 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 and Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Postoperative abduction pillow sling

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, an abduction sling also would not be indicated. The role of surgical process in this case has not been established, thus, negating the need of this postoperative device.

Request for one (1) continuous flow cryotherapy unit between 7/17/2013 and 8/31/2013: 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), Knee and Leg (Acute and Chronic).

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

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, cryotherapy devices are only recommended for up to seven days including

home use following surgeries. The shoulder surgery itself in this case has not been established, thus, negating the need for the role of this postoperative device

Request for one (1) cryotherapy bladder between 7/17/2013 and 8/31/2013: 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), Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: Shoulder Procedure - Continuous-flow cryotherapy

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, cryotherapy devices are only recommended for up to seven days including home use following surgeries. The shoulder surgery itself in this case has not been established, thus, negating the need for the role of this postoperative device.

Request for twelve (12) physical therapy, post-op visits between 7/17/2013 and 8/31/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: Based on California MTUS Postsurgical Rehabilitative Guidelines, 12 postoperative therapy sessions would be indicated, however, as the need for operative intervention in this case has not been established, the need for this request is negated