

Case Number:	CM13-0027146		
Date Assigned:	11/22/2013	Date of Injury:	07/18/2002
Decision Date:	01/28/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/20/2013

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 53-year-old gentleman who was injured in a work related accident on 07/18/02. Records for review indicate continued complaints about the left shoulder. Progress report with [REDACTED] of 07/31/13 gives subjective complaints of increased left shoulder and low back pain after repetitive activities and at night. Objectively, the left shoulder was with positive impingement maneuvers, AC joint pain, 120 degrees of abduction with bicipital tenderness and atrophy to the deltoid muscles. Reviewed was a recent MRI of the left shoulder that showed glenohumeral degeneration, tendinosis, and intrasubstance tearing of the supraspinatus tendon. It was noted to be "virtually full thickness". Given the claimant's clinical findings surgical intervention in the form of decompression, Mumford procedure, and possible rotator cuff repair was recommended. Records indicate that the claimant had previously undergone shoulder procedure noted in records as early as 09/18/12 with formal date unclear. The claimant has also noted to have been treated with conservative measures including a recent corticosteroid injection, medication management and therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

left shoulder revision arthroscopic subacromial decompression, Mumford procedure and possible rotator cuff repair: 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 (ODG)-- Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Partial claviclectomy (Mumford procedure)

Decision rationale: Based on California ACOEM Guidelines and supported by Official Disability Guidelines criteria, surgical process would appear warranted. The claimant's clinical records indicate essentially full thickness pathology to the supraspinatus tendon with noted failed conservative care and continued positive findings of impingement. The claimant at present would meet clinical criteria for the role of the process, particularly including his full thickness tearing to the rotator cuff at present. California ACOEM Guidelines indicate that conservative care for a three to six month period should be utilized including injection therapy before proceeding with procedure; that appears to be the case.

one (1) pain pump: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 (ODG)-- Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Postoperative pain pump

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines criteria, a pain pump is not supported. While the surgical process in this case appears reasonable. The postoperative use of a pain pump is not supported by Official Disability Guidelines criteria in any form of shoulder intervention. This specific request in this case would not be indicated.

30-day rental of motorized hot/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, 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 (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, a 30-day rental of a hot and cold therapy unit is not supported. Official Disability Guidelines does not recommend the role of "combination" therapy devices, nor does it

recommend cold therapy in the form of cryotherapy for more than seven days including home use. This specific request for this combination device for a 30 days rental would exceed guideline criteria and would not be indicated.

one (1) pro-sling with abduction pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 (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, the request for an abductor pillow would not be supported. Official Disability Guidelines criteria in regard to abductor slings indicate their use for a larger massive rotator cuff repairs. Records in this case indicate a "nearly full thickness" tear, but there is no indication of a massive or large repair. The lack of the above would support the need for this postoperative DME device.

one (1) continuous passive motion machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 (ODG)-- Official Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous passive motion (CPM)

Decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guidelines, a continuous passive motion device is not supported. Guideline criteria does not recommend the role of continuous passive motion to the shoulder in any setting, particularly postoperative settings with guideline criteria not supporting long term efficacy. This specific request in this case would not be indicated.

Tizanidine 4mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Antispasticity/Antispasmodic drugs.

Decision rationale: Based on California MTUS Chronic Pain Medical Treatment Guidelines, Tizanidine, a muscle relaxant, would not be indicated. Guidelines do not recommend the role of muscle relaxants for the claimant's current diagnosis of impingement syndrome, nor would muscle relaxants be indicated for long term use without documentation of acute exacerbation of symptoms that would include muscular spasm. Records in this case would not support the role of this agent at this chronic stage in the clinical course of care for the claimant's working diagnosis.

Hydrocodone/APAP 10/325mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-80.

Decision rationale: Based on California MTUS Guidelines, the continued role of Hydrocodone appears warranted. The claimant continues to be treated for symptomatic complaints of shoulder and low back pain. The shoulder pain is with essentially full thickness tearing, for which operative process is being recommended. The continued role of this short acting narcotic analgesic for symptomatic pain relief would appear medically necessary.