

Case Number:	CM13-0041942		
Date Assigned:	05/07/2014	Date of Injury:	06/18/2013
Decision Date:	07/09/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/16/2013

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 51 year old male who was injured on 06/18/2013 while he was hitting a furnace with a metal bar and developed a pain and pop in his right shoulder. A month later he noted back pain. Prior treatment history did not include any medication history in the records. Diagnostic studies reviewed include MRI of the right shoulder revealing mild rotator cuff tendinosis. No evidence of full thickness rotator cuff tear. There was moderate to severe glenohumeral joint arthrosis with diffuse areas of Grade IV cartilage loss of nearly the entire humeral head and central to posterior aspect of the glenoid and mild tendinosis of the intra-articular long head of the biceps tendon. PR-2 dated 09/23/2013 documented the patient with complaints of recurrent shoulder pain and weakness. Objective findings include a glenoid labrum tear. Diagnosis: Superior glenoid labrum tear. Treatment Plan: Right shoulder arthroscopy, SLAP repair. UR report dated 09/30/2013 denied the request for right shoulder arthroscopy, SLAP repair as there was no evidence of conservative treatment provided, all other requests relating to the surgery were denied based on the denied procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY, SLAP REPAIR;: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SHOULDER, SURGERY FOR SLAP LESIONS.

Decision rationale: The California MTUS guidelines have not addressed the issue of dispute. According to the ODG, surgery for SLAP lesions is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. The medical records document the employee was diagnosed with superior glenoid labrum lesion. In the absence of documentation of the type of the lesion and as the request is not indicating arthroscopic diagnosis of the right shoulder lesion, the request is not medically necessary according to the guidelines.

PRE-OP MED CLEARANCE, COMPLETE BLOOD COUNT(CBC), SMA-7, LIPID PANEL, CHEST X-RAY, EKG, PROTHROMBIN TIME(PT),PARTIAL THROMBOPLASTIN TIME(PTT): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

INITIAL POST-OP PHYSICAL THERAPY 2X4 FOR THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

COLD THERAPY UNIT 14-DAYS RENTAL FOR THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

PROPHYLACTIC DEEP VEIN THROMBOSIS (DVT): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.