

Case Number:	CM13-0043198		
Date Assigned:	12/27/2013	Date of Injury:	12/14/2012
Decision Date:	03/12/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/22/2013

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 least at 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:

50 year old female with date of injury 12/14/12. Report of injury to multiple body parts. Exam note 9/30/13 demonstrates complaint of bilateral shoulder pain with popping and clicking. Objective findings demonstrate bilateral shoulder impingement tests. The request is for bilateral shoulder arthroscopy with bilateral elbow night splints. MRI of bilateral shoulders demonstrate Type I superior labrum anterior and posterior (SLAP) lesion with subscapularis tendinosis without associated tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral arthroscopy for the shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 33.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

Decision rationale: Based upon the CA MTUS Shoulder Chapter, Pg 209-210 Referral for surgical consultation may be indicated for patients who have: - Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.) - Activity limitation for more than four months, plus existence of a surgical lesion - Failure to increase ROM and strength of the musculature around the shoulder even after exercise programs, plus existence of a

surgical lesion - Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgical considerations depend on the working or imaging-confirmed diagnosis of the presenting shoulder complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and expectations, in particular, is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. For postsurgical rehabilitation, key indicators for further assessment and treatment include: - Prolonged course - Multiple surgical procedures - Use of narcotic medications. Based upon the lack of documentation of failure of above criteria, the determination is non-certification of diagnostic shoulder criteria.

Bilateral elbow night splint: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (IDG), 17th edition, 2012.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

Decision rationale: Epicondylalgia Supports (Tennis Elbow Bands, Braces or Epicondylitis Straps): Eleven articles were reviewed on orthotics for epicondylalgia, five studies and six meta-analyses. Three of the studies were of intermediate quality and two were of low quality. One study examined a sample of 63 patients with symptoms for 6 weeks or longer in which 30 received treatment with the dynamic extensor brace and 33 received no brace for 12 weeks (there was a crossover period from weeks 12-24, where the no brace group received treatment with the brace).⁵³ The results of the study showed that "12 weeks of brace treatment results in relief of pain, improvement in functionality of the arm, and pain-free grip strength in patients with lateral epicondylitis. The beneficial effects last for at least another 12 weeks after cessation of the brace therapy." Another study evaluated 180 patients (with symptoms for at least 6 weeks) treating them with either physical therapy (n = 56), an Epipoint brace (n = 68) or combination of physical therapy and brace treatment (n = 56).⁵⁴ As the physical therapy regimen was not specified, the results are uninterpretable. The authors concluded that "brace treatment might be useful as initial therapy. Combination therapy has no additional advantage compared to physical therapy but is superior to brace only for the short term [6 weeks]." Quality studies are available on epicondylalgia supports in acute, subacute, and chronic lateral epicondylalgia patients, although the braces most commonly used in research studies are not widely used in the US. There is evidence of benefits. However, these options are low cost, have few side effects, and are not invasive. Thus, while there is insufficient evidence to support their use, they are recommended [Insufficient Evidence (I), Recommended]. In this case there is insufficient evidence of objective findings including EMG/NCV to support bilateral elbow splints.