

Case Number:	CM14-0106847		
Date Assigned:	07/30/2014	Date of Injury:	12/26/2012
Decision Date:	09/09/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/10/2014

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 38-year-old male sustained an industrial injury on 12/26/12. The mechanism of injury was not documented. The patient underwent left shoulder arthroscopic labral repair and subacromial decompression on 5/10/13. The 2/26/14 orthopedic progress report indicated the patient was doing well until about a month ago when the shoulder started making noises and was painful. Physical exam documented 170 degrees forward flexion, 90 degrees abduction, and 4+/5 strength. Physical therapy was recommended. The 5/18/14 progress report cited on-going left shoulder pain and 4/5 weakness. The 5/29/14 left shoulder MRI impression documented a SLAP fracture with grade 4 chondral loss of the humeral head with post-operative type change in the superior labrum biceps labral complex consistent with a previous treated SLAP lesion. There was moderate tenosynovitis of the proximal biceps tendon and mild acromioclavicular joint arthrosis. There was a degenerative labral tear with chondral thinning of the posterior glenoid fossa. There were findings consistent with adhesive capsulitis and a small supraspinatus tear. The 6/9/14 progress report noted MRI findings of labral tear and recommended physical therapy three times a week for six weeks. The 6/25/14 utilization review denied the left shoulder surgery and associated requests as the patient underwent this procedure one year ago with no recent physical exam for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery arthroscopic debridement and labral repair (left shoulder): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Treatment Integrated Treatment/Disability Duration Guidelines (Surgery for SLAP lesions).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for SLAP repair.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines recommend surgery for SLAP lesions after 3 months of conservative treatment and when history, physical exam, and imaging indicate pathology. Guideline criteria have not been met. There is no documentation that physical therapy failed to improve strength and ranges of motion since increased symptoms were documented 2/26/14. There is no current physical exam evidence of range of motion or strength. Therefore, this request is not medically necessary.

Post-operative Physical Therapy (3) times a week for (6) weeks for (18) sessions: 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 Page(s): 27.

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

Durable Medical Equipment Post-operative 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 Treatment Integrated Treatment/Disability Duration Guidelines (shoulder chapter).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy.

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

Durable Medical Equipment Post-op cradle arm sling: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Treatment Integrated Treatment/Disability Duration Guidelines (shoulder chapter).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205,213.

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