

Case Number:	CM14-0119542		
Date Assigned:	08/06/2014	Date of Injury:	02/26/2014
Decision Date:	09/10/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/28/2014

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 27-year-old male police officer sustained an industrial injury on 2/26/14. The injury occurred getting his gear bag (approximately 60 pounds) out of his car. He felt a shoulder pull with onset of significant pain. The 3/12/14 right shoulder MRI impression documented abnormal signal in the superior and posterior labrum, suggestive of a SLAP lesion. There were mild acromioclavicular joint degenerative changes noted with increased risk for impingement syndrome. There was no evidence of partial or full thickness rotator cuff tear. There were tendinopathy changes of the infraspinatus tendon. The treating physician opined a mild brachial plexitis on top of labral issues. His symptoms were consistent with a traction injury. Conservative treatment included a Medrol Dosepak, activity modification, anti-inflammatories, and physical therapy. The 6/10/14 treating physician report cited decreased plexus inflammation with Medrol. The patient attended 10 sessions of physical therapy with better motion and cuff strength. There was residual pain. He remained off work. Physical exam documented biceps tenderness, positive labral signs, and positive O'Brien's. There was tenderness over the plexus distally but no neural tension signs. Yergason's and Speed's tests were negative. The recommendation was for right shoulder arthroscopy, possible SLAP repair.

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: Overturned

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): Surgery for SLAP lesions, SLAP lesion diagnosis, Criteria for Classification of SLAP lesions.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The 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 for surgical repair of SLAP lesions state that SLAP lesions may warrant surgical treatment in certain cases. Surgical intervention may be considered for patients failing conservative treatment. Guideline criteria have been met. This patient presents with continued pain and functional limitation preventing return to work. MRI findings and clinical exam are consistent with a SLAP lesion. The patient has been afforded comprehensive conservative treatment and has improved in range of motion and strength but persistent pain has not allowed return to work. Therefore, this request for right shoulder arthroscopy, SLAP repair is medically necessary.

Medical Clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guide Clearinghouse, Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 Edition, Pages 92-93 - Immediate preoperative visits and other services by physician.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met based on risks of undergoing anesthesia Therefore, this request for medical clearance is medically necessary.

Twelve (12) Post Operative Physical Therapy sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for SLAP repair surgery suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Guideline criteria have been met consistent with initial post-operative treatment. Therefore, this request for twelve (12) post-operative physical therapy sessions is medically necessary.

Seven (7) days of a Vascutherm 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): Regarding continuous-flow cryotherapy.

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

Decision rationale: The California MTUS is silent regarding cold compression devices, like the Vascutherm unit. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder. Guidelines state that there has been a randomized controlled trial since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device, and those using ice bags and elastic wrap after shoulder surgery, but the results are not available. Therefore, this request for VascuTherm cold therapy unit rental for 7 days is not medically necessary.

Shoulder Sling: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic): Immobilization.

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

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request for one shoulder sling is medically necessary.

Post Operative Prescription: Percocet 10/325 #90: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines,

Pain (Chronic): Opioids, specific drug list - Oxycodone/Acetaminophen, Guidelines on pain management. Arnhem, The Netherlands: European Association of Urology (EAU); 2010 Apr. p 61-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE. OPIOIDS, SPECIFIC DRUG LIST Page(s): 76-80, 92.

Decision rationale: The California MTUS guidelines support the use of Percocet for moderate to moderately severe pain on an as needed basis. Guidelines support an initial dose of 2.5 to 5 mg and allow doses from 10 to 30 mg for severe pain. Short-acting opioids, also known as normal-release or immediate-release opioids, are seen as an effective method in controlling both acute and chronic pain. Guideline criteria have been met for the post-operative use of Percocet. Therefore, this post-operative prescription of Percocet 10/325 mg #90 is medically necessary.

Post-Operative Prescription: Oxycontin 10mg #28: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic): Opioids, specific drug list - Oxycodone immediate release, Guidelines on pain management. Arnhem, The Netherlands: European Association of Urology (EAU); 2010 Apr. p 61-82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE. OPIOIDS, SPECIFIC DRUG LIST Page(s): 76-80, 92.

Decision rationale: The California MTUS recommends Oxycontin for the management of moderate to severe pain when a continuous, around the clock analgesic is needed for an extended amount of time. Oxycontin is not intended for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that the patient will require around the clock analgesia for an extended period of time. There is no indication that the certified request for Percocet would be sufficient to manage post-operative pain complaints. Therefore, this post-operative prescription for Oxycontin 10 mg #28 is not medically necessary.