

Case Number:	CM14-0164351		
Date Assigned:	10/09/2014	Date of Injury:	07/21/2013
Decision Date:	11/10/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/06/2014

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 Orthopaedic Surgery and is licensed to practice in Texas. 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:

The injured worker is a 30 year old female deputy sheriff with a date of injury on 7/21/13. Injury occurred during an altercation with a suspect. Her shoulder was pushed forward and down causing three pops and dislocation. A right shoulder Bankart repair was performed on 12/10/13. On-going difficulties were reported in the post-operative period with range of motion deficits, functional limitations, and persistent pain. The 7/18/14 treating physician report cited complaints of right shoulder impingement type pain with some improvement in range of motion. A physical exam documented tightness at end range, decrease in internal rotation, and positive impingement signs. Instability signs did not appear to be positive, or at best trace positive. A corticosteroid injection was provided to the right shoulder. The 7/25/14 treating physician report indicated the injured worker did not get much relief of symptoms following the injection. There was still fairly significant pain with overhead activity. Pinching in the shoulder was reported. Right shoulder range of motion was 150 degrees in flexion and abduction with positive impingement signs. A magnetic resonance (MR) arthrogram was requested. The 8/11/14 right shoulder magnetic resonance (MR) arthrogram impression documented post-operative changes of labral repair in the anterior and anteroinferior glenoid labrum. There was tearing in the posterior, posterosuperior, and superior labrum with slight progression of the tear posteriorly. There was resolution of the bone marrow contusion in the posterior aspect of the humeral head. Os acromiale was noted. Records indicated that 31 physical therapy visits had been completed as of 8/19/14. The 8/26/14 treating physician report cited anterior right shoulder pain particularly with overhead activities. She had difficulty reaching for things due to lack of range of motion. Right shoulder exam documented nearly full passive range of motion but active forward flexion and abduction were limited to about 110 to 120 degrees. There was some pain with abduction and posterior thrust of her shoulder particularly at about 110 degrees of elevation. The magnetic

resonance (MR) arthrogram demonstrated the anterior repair had healed, and the bone marrow contusion in the humeral head was resolved. There was a progression of the posterior labral tear. Non-operative measures had not given lasting relief and pain persisted. Authorization was requested for right shoulder arthroscopy to repair the posterior labrum. The 9/16/4 utilization review denied the right shoulder surgery and associated requests as there were no clinical mechanical symptoms reported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, repair posterior labrum: Overturned

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

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 lesions

Decision rationale: The evidence based guidelines state that surgical consideration may be indicated for injured workers 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 state that superior labrum anterior posterior (SLAP) lesions may warrant surgical treatment in certain cases and may be considered for injured workers failing conservative treatment. Guidelines typically support surgery after 3 months of conservative treatment when history, physical exam, and imaging indicate pathology. Guideline criteria have been met. This injured worker has failed over 6 months of extensive conservative treatment, including physical therapy, activity modification, medications, injections, and home exercise. There is persistent right shoulder pain and functional limitations that preclude return to full duty work. Impingement symptoms and signs are present on clinical exam. Range of motion remains limited. Imaging has confirmed a progressive superior labral tear. Therefore, this request is medically necessary. There is imaging evidence of a progressive labral tear with supporting clinical signs and symptoms. Comprehensive conservative treatment failure over 6 months is documented. The request is medically necessary.

Post-op physical therapy x9 sessions, Rt shoulder: 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 Medical Treatment Utilization Schedule (MTUS) Post-Surgical Treatment Guidelines for impingement syndrome 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. This initial request for post-operative physical therapy is consistent with guidelines. Therefore, this request is medically necessary. The surgery has now been approved. This request is consistent with guidelines. Therefore the request is medically necessary.

Polar care: Upheld

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

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: The California Medical Treatment Utilization Schedule are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days. Guideline criteria have not been met. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Shoulder brace: Overturned

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

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

Decision rationale: The evidence based guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for injured workers 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 is medically necessary. The surgery has now been approved. This request is consistent with guidelines. Therefore the request is medically necessary.