

Case Number:	CM14-0063561		
Date Assigned:	07/11/2014	Date of Injury:	01/17/2008
Decision Date:	09/24/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/06/2014

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 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:

The claimant is a 60-year-old, gentleman who injured his right shoulder on 01/17/08. The clinical records provided for review include the report of an MRI of the right shoulder dated 02/13/14 showing inflammatory findings with no evidence of rotator cuff or labral pathology. The report of the office consultation dated 03/27/14 described continued complaints of shoulder and right knee pain. Physical exam showed 90 degrees of active elevation and internal rotation with positive impingement sign. The report documented that the claimant was status post rotator cuff repair times two in August 2011 and January 2013. Based on failed conservative measures, the recommendation was made for right shoulder arthroscopy, rotator cuff and labral repair with 12 postoperative sessions of therapy, a cryotherapy device and an Ultra Sling.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopic rotator cuff repair and possible labral repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation Official Disability Guidelines: Shoulder, Labral Tears.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Surgery for SLAP lesions

Decision rationale: Based on the California ACOEM Guidelines, the request for right shoulder arthroscopic rotator cuff repair and possible labral repair cannot be supported as medically necessary. The records indicate the claimant has undergone two prior rotator cuff repair procedures in 2011 and 2013. The result of recent postoperative imaging does not demonstrate recurrent tearing of the rotator cuff or labral pathology. There is also no clear documentation of recent conservative measures offered to the claimant for his symptoms. Given the claimant's current clinical presentation, including imaging findings, the acute need of a right shoulder arthroscopic rotator cuff repair and possible labral repair is not medically necessary.

Twelve (12) sessions of Physical Therapy: 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.

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

Cold Therapy Unit: Upheld

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): 212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp; 18th Edition; 2013 Updates; Chapter Shoulder; Continuous-flow Cryotherapy Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating.

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

Ultra Sling: 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) Treatment in Worker's Comp; 18th Edition; 2013 Updates; Shoulder Chapter; Postoperative abduction pillow sling

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