MAXIMUS Federal Services

Case Number:	CM15-0045539		
Date Assigned:	03/17/2015	Date of Injury:	10/08/2012
Decision Date:	05/11/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/10/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 50-year-old male who reported an injury on 10/08/2012. The mechanism of injury was not stated. The current diagnoses include labral tear, rotator cuff tear, and impingement. The injured worker presented on 02/18/2015 for a follow-up evaluation with complaints of left shoulder pain. Upon examination, full range of motion, normal rotator cuff strength, positive O'Brien's testing, and positive Neer testing. A previous MRI reportedly revealed a partial thickness rotator cuff tear, SLAP tear, and impingement. The provider recommended surgical intervention in the form of a left shoulder arthroscopy; rotator cuff debridement versus repair; subacromial decompression; and open subpectoral biceps tenodesis with labral debridement. Postoperative durable medical equipment was also recommended. The official MRI of the left shoulder was submitted for this review, documented on 02/11/2015, and confirmed a type 4 SLAP tear of the superior glenoid labrum, with supraspinatus tendinopathy and fraying of the articular surface fibers consistent with a small intrasubstance full thickness tear. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy rotator cuff debridement vs repair, subacromial decompression, open subpectorals biceps tenodesis, labral debridement: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. In this case, the injured worker does have positive findings upon MRI, as well as positive examination findings. However, according to the California MTUS/ACOEM Practice Guidelines, the preferred procedure is usually an arthroscopic decompression which involves debridement of the inflamed tissue; lysis; removal of coracoacromial ligament, and possible removal of the outer clavicle. In this case, the injured worker has a type IV SLAP tear that would not respond to a steroid injection or physical therapy. Therefore, the request can be determined as medically necessary in this case.

Post-operative Physical Therapy QTY: 16: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10.

Decision rationale: The California MTUS Guidelines state, the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. Post-surgical treatment for impingement syndrome includes 24 visits over 14 weeks. A post-operative course of 12 sessions would then be supported. The request for 16 sessions exceeds Guideline recommendations. Therefore, the request is not medically necessary.

Slingshot: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Shoulder Chapter (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

Decision rationale: The Official Disability Guidelines recommend a post-operative abduction pillow sling following surgery for a repair of a large and massive rotator cuff tear. A sling is not recommended following an arthroscopic surgery. The injured worker has been issued

authorization for an arthroscopic left shoulder surgery. Therefore, the injured worker does not meet criteria. As such, the request is not medically necessary.

Polar care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Shoulder Chapter (Acute & Chronic).

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

Decision rationale: The Official Disability Guidelines recommend continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request as submitted failed to indicate the total treatment duration. Guidelines would not support a unit purchase, as they only recommend 7-day use. Therefore, the request is not medically necessary.