

<b>Case Number:</b>	CM13-0058978		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	04/13/2011
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	10/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 patient is a 50 year old female who sustained a work related injury on April 13, 2011. There was no mechanism of injury documented. According to the treating physician's report on September 10, 2013, the patient was diagnosed with left shoulder sprain/strain with acromioclavicular joint narrowing per X-ray; rotator cuff tendinosis with partial thickness tear of the supraspinatus, acromioclavicular joint arthrosis, degeneration and tearing of the superior labrum and biceps tendinosis of the anchor per the magnetic resonance imaging (MRI) and bilateral carpal tunnel syndrome per Electromyography (EMG) in May 2011. No surgical interventions were noted. The patient continues to experience left shoulder pain and stiffness with occasional tingling in the 4th and 5th fingers. The patient has received cortisone injections to the left shoulder, the last one being In February 2103 with short term relief. According to the treating physician's evaluation on September 10, 2013, the left shoulder forward flexion is 0 to 150 degrees, abduction 140 degrees, external rotation 50 degrees, and internal rotation 70 degrees. Hawkins and Neer tests were positive with crepitus and pain. There was mild Tinels sign at the elbow and compression of the ulnar nerve at Guyon's canal. Current medications are Motrin and Terocin cream. The injured worker remains on temporary total disability (TTD). The physician requested authorization for platelet-rich plasma injection for the left shoulder. On October 23, 2013 the Utilization Review denied certification for platelet-rich plasma injection for the left shoulder. The Medical Treatment Utilization Schedule (MTUS), Chronic Pain and the American College of Occupational and Environmental Medicine (ACOEM) does not address the

request therefore the Official Disability Guidelines (ODG) Shoulder, Platelet-rich plasma (PRP) was utilized in the decision process.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Platelet rich plasma injection for the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Platelet Rich Plasma (PRP)

**Decision rationale:** The MTUS is silent on Platelet Rich Plasma (PRP) injections, but according to the ODG, under study as a solo treatment. Recommend PRP augmentation as an option in conjunction with arthroscopic repair for large to massive rotator cuff tears. (Jo, 2013) PRP looks promising, but it may not be ready for prime time as a solo treatment. PRP has become popular among professional athletes because it promises to enhance performance, but there is no science behind it yet. In a blinded, prospective, randomized trial of PRP vs placebo in patients undergoing surgery to repair a torn rotator cuff, there was no difference in pain relief or in function. The only thing that was significantly different was the time it took to do the repair; it was longer if you put PRP in the joint. There were also no differences in residual defects on MRI. (AAOS, 2010) Platelet-rich plasma did not help patients recover from arthroscopic rotator cuff surgery in this study. (Jo, 2011) Platelet-rich fibrin matrix (PRFM) applied to the site of rotator cuff tendon repair does not improve healing, and in fact might impair it. There was a significantly higher failure rate in the PRFM group than in the control group for double-row/transosseous-equivalent repairs at 12 weeks. The PRFM used in the study was the Cascade Autologous Platelet System. (Rodeo, 2012). PRP is still a developing treatment and is only recommended in conjunction with arthroscopic repair for large to massive rotator cuff tears. The treating physician has not documented a large or massive rotator cuff tear. The treating physician states that the PRP is to augment cortisone injections. However, guidelines do not support PRP for this use.