

Case Number:	CM15-0047334		
Date Assigned:	04/13/2015	Date of Injury:	03/13/2014
Decision Date:	05/13/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/12/2015

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: Illinois, California, Texas Certification(s)/Specialty: Orthopedic Surgery

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 53-year-old female who sustained an industrial injury on 3/13/14. She reported an acute onset of sharp pain in her right knee, left leg, and low back while driving a bus. The 10/20/14 right shoulder MRI impression documented advanced supraspinatus tendinopathy with multifocal bursal surface fraying and partial thickness tears, tendinopathy and bursal surface partial thickness tearing extending into the anterior portion of the distal infraspinatus, and mild supraspinatus muscle belly atrophy. There was moderate AC joint hypertrophic changes, degenerative irregularities, and associated moderate reactive osteitis throughout the distal clavicle. There was moderate lateral down sloping of the acromion, findings consistent with subacromial/subdeltoid bursitis, biceps tendinopathy at the level of the pulley, and intrasubstance degenerative-type SLAP labral tear. The 2/19/15 treating physician report cited right shoulder pain, mainly activity related but also at rest. There was difficulty raising her shoulder without some weakness and pain. She had typical bursitis and impingement symptoms including pain with forward elevation, internal rotation and reaching behind the back. She had not improved with conservative treatment at this time. Right shoulder exam documented very mild tenderness over the acromioclavicular (AC) joint and along the anterior acromion and laterally. There were strength deficits in abduction, forward flexion, and subluxation. Impingement, signs were positive. O'Brien's and lift off tests were negative. There was no bicipital tendinitis or muscle atrophy noted. There was normal biceps and triceps strength, and full shoulder range of motion. The diagnosis included right shoulder rotator cuff tear with SLAP tearing. The treatment plan requested authorization for arthroscopic rotator cuff repair, subacromial decompression, evaluation and possible repair of the labrum if necessary, and the same for distal clavicle with possible Mumford, and a cryotherapy unit. The 3/6/15 utilization review certified a request for right shoulder arthroscopy with subacromial decompression and rotator cuff repair. The request

for right shoulder arthroscopy with labral repair was non-certified, as SLAP tear repair is not supported for patients over 50 years of age. The request for purchase of a cold therapy unit was denied as ice packs work just as efficiently.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with labral 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.

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 repair.

Decision rationale: The California MTUS 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 recommend surgery for SLAP lesions after 3 months of conservative treatment for Type II or IV lesions, when history and physical exam and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presented with persistent right shoulder pain and functional limitations. Clinical exam findings were consistent with imaging evidence of rotator cuff tear and impingement. There was imaging evidence of labral pathology. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Guidelines support diagnostic arthroscopy for definitive diagnosis and evaluation of SLAP lesions. Labral repair is supported in the form of biceps tenodesis for patients over 50. Therefore, this request is medically necessary.

Associated Surgical Service: Cold therapy unit purchase for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder (updated 10/31/14).

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 MTUS 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, including home use. 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 purchase, which is not consistent with guidelines. Therefore, this request is not medically necessary.