

Case Number:	CM13-0031947		
Date Assigned:	12/04/2013	Date of Injury:	06/03/2011
Decision Date:	02/05/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopaedic 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 physician 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:

43 year old male with report of industrial injury 6/3/11. MR arthrogram 8/26/13 demonstrates postoperative changes status post distal clavicle resection with superior labrum tearing. Exam note from 9/9/13 demonstrates full motion of shoulder with associated pain. 5/5 rotator cuff strength. No evidence of differential injection or physical therapy performed. Request for right shoulder arthroscopy with debridement labrum and biceps tenodesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy with debridement, trim, labrum, biceps tenodesis: 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)

Decision rationale: The Official Disability Guidelines, regarding surgery for SLAP lesions states "Recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. The advent of shoulder arthroscopy as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously diagnosed lesions involving the superior labrum and biceps tendon anchor." According to the Official

Disability Guidelines regarding surgery for ruptured biceps tendon, "Criteria for tenodesis of long head of biceps (consideration of tenodesis should include the following: patient should be a young adult; not recommended as an independent stand-alone procedure. There must be evidence of an incomplete tear) with diagnosis of incomplete tear or fraying of the proximal biceps tendon (the diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review): 1. Subjective clinical findings: complaint of more than 'normal' amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery PLUS 2. Objective clinical findings: partial thickness tears do not have classic appearance of ruptured muscle PLUS 3. Imaging clinical findings: same as that required to rule out full thickness rotator cuff tear: conventional x-rays, AP and true lateral or axillary view AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. Criteria for tenodesis of long head of biceps with diagnosis of complete tear of the proximal biceps tendon: surgery almost never considered in full thickness ruptures. Also required: 1. Subjective clinical findings: pain, weakness and deformity PLUS 2. Objective clinical findings: classical appearance of ruptured muscle. Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: all should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed." In this case there is insufficient evidence in the medical record to support the above procedure. There is no evidence of differential injections to the biceps tendon to attempt to identify pain generator. There is insufficient evidence of post-surgical therapy to warrant revision surgery. Therefore the determination is non-certification.

Post-op physical therapy two (2) times a week for six (6) weeks for the right shoulder:
Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Right shoulder ultra sling is not medically necessary and appropriate.: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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: The Expert Reviewer did not cite any medical evidence for its decision.

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