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| Case Number: | CM13-0037655 | | |
| Date Assigned: | 04/28/2014 | Date of Injury: | 12/04/2003 |
| Decision Date: | 06/10/2014 | UR Denial Date: | 09/12/2013 |
| Priority: | Standard | Application Received: | 09/25/2013 |

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. 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 patient is a 45 year old male who was injured on 12/04/2013 when he hit his left shoulder against a fire hydrant. Prior treatment history has included the patient undergoing right shoulder surgery in 2002. Diagnostic studies reviewed include MRI of the left shoulder dated 03/07/2013 revealing degenerative joint disease at the glenohumeral joint and severe biceps tendinitis. There is also inflammation indicative of impingement. An x-ray of the left shoulder dated 07/26/2013 revealed osteoarthritis. Progress note dated 05/31/2013 documented the patient has had all appropriate non-operative treatment including physical therapy, physical modalities, non-steroidal anti-inflammatory medications, activity modifications and injections. The patient is not presently taking any medications. Objective findings on examination of the right shoulder revealed a normal exam. Examination of the left shoulder revealed the following range of motion: abduction and forward flexion 90 degrees on left and 180 degrees on right. Neer, Hawkin's, speed test and Yergason's tests were all positive. There is tenderness to palpation of the shoulder. Assessment/Plan: His diagnosis is degenerative joint disease at the glenohumeral joint, severe biceps tendinitis and impingement. At this point I recommend that the patient undergo shoulder arthroscopy, subacromial decompression and biceps tendinosis. Synovectomy and clean out of the joints shoulder also be performed. If the patient does not improve with surgery then he may be a candidate for shoulder replacement surgery. It is impossible to differentiate exactly where the pain is coming from as the glenohumeral joint, biceps tendon or rotator cuff could be the reason.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE ORTHOPEDIC SURGEON FOR ARTHROSCOPIC BICEPS TENODESIS SURGERY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

Decision rationale: According to Shoulder Complaints Chapter ACOEM Practice Guidelines, surgical intervention is not recommended for ruptured biceps "Ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively because there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young bodybuilders, but is not necessary for function". In this case, the medical record dated 05/31/2013 documents that the patient had all non-operable treatment including physical therapy, chiropractic care, HEP, medications, and cortisone injections, but it did not clarify sufficient information about the duration and frequency of these conservative measures. As per ODG, "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 medical records indicate that the MRI of left shoulder dated 03/07/2013 showed degenerative joint disease at glenohumeral joint, severe biceps tendinitis and impingement, but there is no documentation of tear. Furthermore, as documented in the medical records, the shoulder pain is not exclusively addressed to the long head of the biceps muscle. Therefore, since the proposed arthroscopic biceps tenodesis surgery is not medically necessary according to the guidelines and clinical findings, the medical necessity has not been established for 1 orthopedic surgeon. Hence, the request is not medically necessary.