

Case Number:	CM13-0066293		
Date Assigned:	01/03/2014	Date of Injury:	02/06/2008
Decision Date:	03/27/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/16/2013

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:

This 57-year-old male has a history of left shoulder pain relative to cumulative trauma, date of injury 2/6/08. The 3/25/13 left shoulder MRI revealed an extensive chronic degenerative labral tear including SLAP component, chronic longitudinal split thickness tear of the long head of the biceps tendon, mild partial intrasubstance tear with fraying of the supraspinatus tendon, moderate subscapularis tendinosis and mild infraspinatus tendinosis without tear, and moderate acromioclavicular joint hypertrophy with mild osteoarthritis. The 10/2/13 EMG/NCV findings showed mild bilateral carpal tunnel syndrome and left cubital tunnel syndrome. The 10/22/13 treating physician report noted constant stabbing left shoulder pain. Left shoulder exam findings noted flexion and abduction 0-80 degrees with normal upper extremity strength and reflexes. The 11/19/13 surgical request noted a fair amount of biceps inflammation, anterior shoulder pain, pain with overhead activity and lifting, pain at night, and limited motion. Left upper extremity numbness and tingling was noted at the elbow and carpal tunnel. An arthroscopic evaluation of the left shoulder with labral repair, biceps tenodesis, evaluation of the rotator cuff to debride any partial tear, and acromioplasty has been requested

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder scope with labral repair: 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), Shoulder, Surgery for SLAP Lesions

Decision rationale: The request under consideration is for a left shoulder arthroscopy with labral repair. This patient has chronic and multiple and rather severe ongoing degenerative findings. The California MTUS guidelines do not address shoulder arthroscopy for chronic injuries. The Official Disability Guidelines for surgical repair of SLAP lesions state that SLAP lesions may warrant surgical treatment in certain cases. Surgical intervention may be considered for patients failing conservative treatment. Detailed and recent non-operative treatment trials and failures (including medications, injections, PT and restricted activities) have not been documented. Given guideline criteria having not been met; the request for left shoulder arthroscopy with labral repair is not medically necessary

Possible rotator cuff repair: 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), Shoulder, Rotator Cuff Repair

Decision rationale: The request under consideration is a possible rotator cuff repair. MRI findings showed a mild partial intrasubstance tear with fraying of the supraspinatus tendon, no full thickness defect. The California MTUS guidelines do not address rotator cuff repair for chronic injuries. The Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Exam findings documented normal upper extremity strength with no evidence of impingement. Recent detailed comprehensive non-operative treatment is not documented as having been tried and failed. Given the failure to meet guideline criteria, the request for possible rotator cuff repair is not medically necessary.

Possible bicep tendonsis: 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), Shoulder, Biceps Tenodesis

Decision rationale: The request under consideration is a possible biceps tenodesis. MRI findings showed a chronic longitudinal split thickness tear of the intracapsular portion of the long head of the biceps tendon. The California MTUS guidelines do not address biceps tenodesis for chronic

injuries. The Official Disability Guidelines for biceps tenodesis state that nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendon. Recent detailed comprehensive non-operative treatment is not documented as having been tried and failed. Given the failure to meet guideline criteria, the request for possible biceps tenodesis is not medically necessary.

Acromioplasty: 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), Shoulder, Acromioplasty

Decision rationale: The request under consideration is an acromioplasty. MRI findings showed moderate acromioclavicular joint hypertrophy with mild osteoarthritis. The California MTUS guidelines do not address acromioplasty for chronic injuries. The Official Disability Guidelines for acromioplasty require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Exam findings documented normal upper extremity strength with no evidence of impingement. Recent detailed comprehensive non-operative treatment is not documented as having been tried and failed. Given the failure to meet guideline criteria, the request for acromioplasty is not medically necessary.