

Case Number:	CM14-0043510		
Date Assigned:	07/02/2014	Date of Injury:	03/22/2013
Decision Date:	12/24/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/10/2014

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:

62 year-old male with reported industrial injury on 4/1/13. Exam February 6, 2014 demonstrates a chief complaint right shoulder pain. Cortisone injection 4 weeks prior is noted to help alleviate some symptoms. Shoulder range of motion is noted to be unrestricted. Exam note 5/14/14 demonstrates complaints of pain in the right shoulder. MRI right shoulder from May 22, 2013 demonstrates full-thickness tears of the supraspinatus tendon and infraspinatus tendon with retraction and atrophy. Tendinosis and partial tearing long head of the biceps tendon is noted. Examination demonstrates inspection of the shoulder was normal. Range of motion of the shoulder is noted to be moderately restricted. There is complaint of severe pain with movement of the joint. No palpable clicking, palpable grinding of the shoulder is noted throughout the range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right biceps tenodesis Qty: 1.00: 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, Tenodesis long head of biceps

Decision rationale: CA MTUS/ACOEM is silent on the issue of biceps tenodesis. According to the Official Disability Guidelines, Criteria for tenodesis of long head of biceps include subjective clinical findings including objective clinical findings. In addition there should be imaging findings. Criteria for tenodesis of long head of biceps include a diagnosis of complete tear of the proximal biceps tendon. In this case the MRI from 5/22/13 does not demonstrate evidence of degree that the biceps tendon is partially torn or frayed or failed nonsurgical management to warrant tenodesis. Therefore the determination is not medically necessary.

Right hemiarthroplasty Qty: 1.00: 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, Arthroplasty

Decision rationale: CA MTUS/ACOEM is silent on this issue of shoulder replacement. According to the ODG Shoulder section, arthroplasty "The most common indication for total shoulder arthroplasty is osteoarthritis, but for hemiarthroplasty it is acute fracture. There was a high rate of satisfactory or excellent results after total shoulder arthroplasty for osteoarthritis, but hemiarthroplasty offered less satisfactory results, most likely related to the use of this procedure for trauma." Shoulder arthroplasty is indicated for glenohumeral and acromioclavicular osteoarthritis with severe pain with positive radiographic findings and failure of 6 months of conservative care. In this case there is insufficient evidence in the records of failure of conservative care. Therefore the determination is not medically necessary.

Post Op PT 2x6 Qty: 12.00: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-Op Ultras Sling Qty 1.00: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-Op cold therapy unit Qty: 1.00: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.