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| <b>Case Number:</b>   | CM15-0166329 |                              |            |
| <b>Date Assigned:</b> | 09/04/2015   | <b>Date of Injury:</b>       | 12/15/2014 |
| <b>Decision Date:</b> | 10/26/2015   | <b>UR Denial Date:</b>       | 08/07/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/24/2015 |

### 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: California, Indiana, Oregon  
 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 62-year-old male who sustained an industrial injury on 12-15-14 when he was moving a box resulting in injury to his left shoulder. He currently complains of constant pain at the lateral left shoulder radiating from the neck and down to the wrist. There has been no improvement per 7-23-15 note. On physical exam of the left shoulder, there was tenderness to palpation, positive Neer and Hawkins impingement sign and positive O'Brien's test. Diagnoses were left shoulder subdeltoid bursitis, left shoulder long head biceps tendinosis and tenosynovitis. Treatments o date include physical therapy without benefit, medications and injections. In the progress note dated 6-11-15 the treating provider's plan of care includes requests for left shoulder arthroscopy, open subpectoral tenodesis as there has been no improvement in over six months; pre-operative medical clearances; post-operative physical therapy to the left shoulder twice weekly for six weeks; cold therapy unit, 14 day rental; left shoulder immobilizer, purchase.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy, Open Subpectoral Biceps Tenodesis: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 07/30/15) - Online Version Diagnostic arthroscopy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

**Decision rationale:** The CA MTUS/ACOEM Guidelines are 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 and failure of 3 months of physical therapy. Criteria for tenodesis of long head of biceps include a diagnosis of complete tear of the proximal biceps tendon. In this case, the MRI does not demonstrate evidence that the biceps tendon is partially torn or frayed to warrant tenodesis. Therefore, the request is not medically necessary.

**Pre-Operative Medical Clearance:** 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.

**Post-Operative Physical Therapy (12-sessions, 2 times a week for 6-weeks):** 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.

**Associated Surgical Service: Cold Therapy Unit (14-day rental):** 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.

**Associated Surgical Service: Left Shoulder Immobilizer (purchase):** 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.