

Case Number:	CM15-0021943		
Date Assigned:	02/11/2015	Date of Injury:	11/07/2012
Decision Date:	04/07/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/05/2015

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

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 63 year old female who sustained an industrial related injury on 11/7/12. The injured worker had complaints of pain in the left thumb/wrist, index, and middle fingers. Diagnoses included left small finger metacarpal neck fracture, left hand osteoarthritis, left flexor pollicis longus tenosynovitis, bilateral median nerve entrapment at the wrists, left ulnar nerve entrapment at the elbow, and right hand symptoms due to overuse. Left small finger and ring finger flexor tenosynovitis with triggering, left ulnohumeral pain, left tricompartamental osteoarthritis at the elbow, left epicondylitis, left mild tendinopathy of the triceps insertion, and left thumb osteoarthritis were also noted. Treatment included left median nerve decompression at the wrist, pulley release on 6/16/14 and elbow injections on 3/21/14. MRI left shoulder 11/30/13 demonstrates mild tendinosis of supraspinatus and infraspinatus without evidence of rotator cuff tear. SLAP tear is noted. Exam note 12/12/14 demonstrates left shoulder pain. Decreased range of motion and increased pain is noted. Tenderness is noted over the biceps tendon. The treating physician requested authorization for left shoulder arthroscopy, biceps tenodesis, and labral debridement. Other associated requests were for an electrocardiogram, lab work, chest x-ray, clearance, 12 physical therapy treatments, cold therapy unit, and a continuous passive motion machine. On 1/29/15 the requests were non-certified. Regarding the surgical procedure, the utilization review (UR) physician cite the Official Disability Guidelines and noted there is insufficient information on the conservative treatment of the left shoulder with respect to rehab, number of visits and the outcome. Therefore the request was non-certified. Due to the non-certification of the surgery requested the associated requests were also non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Biceps Tenodesis, and Labral Debridement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Labral tear surgery.

Decision rationale: CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. According to ODG, Shoulder, labral tear surgery, it is recommended for Type II lesions and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. There is insufficient evidence from the exam note of 12/12/14 to warrant labral repair secondary to lack of physical examination findings, lack of documentation of conservative care or characterization of the type of labral tear. Therefore determination is for non-certification.

Associated Surgical Services: EKG, Lab Work, Chest X-Ray, and Clearance: 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, Low Back, Preoperative testing.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Physical Therapy, #12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous flow cryotherapy.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Continuous Passive Motion Machine: 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, Shoulder, CPM.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.