

Case Number:	CM15-0031881		
Date Assigned:	02/25/2015	Date of Injury:	05/30/2013
Decision Date:	04/15/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	02/20/2015

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: Minnesota, Florida
 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 39-year-old female who sustained a work related injury May 30, 2013. History included a right rotator cuff repair and carpal tunnel release on 10/10/2013 and a left carpal tunnel release in February 2014. According to an orthopedic physician's report dated January 13, 2015, the injured worker presented with right shoulder joint pain and stiffness with weakness and tingling of the hands. She describes the pain as constant with a burning sensation. Physical examination revealed tenderness, crepitus, and muscle spasms of the shoulder. There is palpable discomfort to the biceps tendon and bicipital groove. The Speed's and Apley's test are positive and there is a positive impingement sign. An MR arthrogram of the right shoulder on 4/10/2014 revealed rotator cuff tendinopathy but no tear. Mild blunting of the labrum was noted. There was no displacement of the long head of biceps tendon. Diagnoses included persisting impingement syndrome and rotator cuff tendinitis with biceps tendinitis. Treatment plan included request for authorization of shoulder surgery. According to utilization review dated January 21, 2015, the request for Right Shoulder Acromioplasty, Right Shoulder Bicep Tenodesis is non-certified, citing MTUS and Official Disability Guidelines (ODG). The request for Post-Operative Physical Therapy 18 Sessions is non-certified, citing MTUS ACOEM Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Acromioplasty, Right Shoulder Bicep Tenodesis: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211 ,213. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Biceps tenodesis.

Decision rationale: The injured worker is a 39-year-old female who underwent a right rotator cuff repair and right carpal tunnel release on 10/10/2013. She complains of recurrent right shoulder pain. An MR arthrogram of the right shoulder dated April 10, 2014 showed rotator cuff tendinopathy but no tear. There was mild blunting of the labrum but no labral tear was documented. The biceps tendon was located in the groove with no displacement. The surgical request is for acromioplasty of the right shoulder and biceps tenodesis. The documentation submitted indicates one injection into the shoulder on 8/26/2014. California MTUS guidelines indicate 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The guidelines recommend conservative care for at least 3-6 months before considering surgery. The documentation submitted does not include such a rehabilitation program. ODG criteria for biceps tenodesis include 3 months of physical therapy and nonsteroidal anti-inflammatory drugs and type II SLAP lesions or type IV slap lesions. In addition, patients undergoing concomitant rotator cuff repair and history and physical examination and imaging indicate pathology. The MR arthrogram revealed mild blunting of the labrum but no tear. The necessary conservative treatment has not been documented. As such, the request for acromioplasty and biceps tenodesis is not supported and the medical necessity of the request has not been substantiated.

Post OP Physical Therapy 18 sessions: 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.