

Case Number:	CM15-0044491		
Date Assigned:	03/16/2015	Date of Injury:	12/10/2013
Decision Date:	05/05/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/09/2015

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: Illinois, California, Texas
 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 50-year-old male who sustained an industrial injury on 12/10/13. Past surgical history was positive for a left shoulder surgery. The 8/27/14 treating physician report cited left shoulder pain with swelling in the trapezial area, and numbness and tingling in the left shoulder and arm. He was going to physical therapy. Physical exam documented significant swelling in the anterior aspect of the trapezial area with some fullness but no spasms. Left shoulder range of motion was elevation 155, internal rotation 65, and external rotation 65 degrees. Rotator cuff strength was 4+/5. Sensation was diminished in the C6 dermatome. He was status post repair and debridement and partial thickness rotator cuff tear. He was noted to have a full thickness biceps tendon rupture at the time of surgery that was not repaired. He appeared to be making very slow progress following his rotator cuff debridement and decompression. He had continued functional strength and range of motion deficits and needed additional physical therapy. Authorization was requested for left upper extremity nerve conduction studies to evaluation the persistent numbness, tingling and diminished C6 dermatomal sensation. The 11/14/14 treating physician report cited typical discomfort at the bicipital tendon. MRI did not show any signs of a rotator cuff tear or biceps tendon problem. EMG showed mild to moderate carpal tunnel syndrome. The treatment plan recommended a left shoulder corticosteroid injection. The 1/8/15 orthopedic report stated that the 10/31/14 left shoulder MRI showed a type 2 acromion and mild acromioclavicular (AC) joint osteoarthritis. The diagnosis was left shoulder pathology, long head biceps tendon tear, and AC joint arthropathy. Authorization was requested for left shoulder subacromial decompression, rotator cuff repair, mini-open biceps tenodesis and

post-op physical therapy. The 2/11/15 utilization review non-certified the left shoulder subacromial decompression, rotator cuff repair, and mini-open biceps tenodesis and post-operative physical therapy requests as there were no recent exam findings with deficits, no prior operative note for review, no rotator cuff tear on MRI, and no documented failure of recent conservative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder SAD, RCR, mini open biceps tenodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for impingement syndrome; Surgery for rotator cuff repair; Surgery for ruptured biceps tendon (at the shoulder).

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional x-rays, AP, and true lateral or axillary view, and an MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. For rotator cuff repair, criteria additionally include imaging evidence of a rotator cuff deficit. The ODG do not support surgery for complete rupture of the long head biceps tendon. Guideline criteria have not been met. This patient presents with a history of left shoulder pain. He is status post left shoulder decompression and rotator cuff debridement surgery. There are no recent clinical exam findings documented. A recent MRI reportedly showed no rotator cuff repair or biceps pathology, but demonstrated a type 2 acromion and mild AC joint osteoarthritis. Prior operative findings reportedly included a full thickness biceps tendon rupture. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. There is no documented response to a recent corticosteroid injection. Given the absence of clinical findings or imaging evidence of impingement/rotator cuff tear, and lacking guideline support for surgical repair of ruptured biceps tendons, this request is not medically necessary.

Post-Operative Physical Therapy (6-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.