Case Number:	CM15-0048774		
Date Assigned:	03/20/2015	Date of Injury:	06/05/2013
Decision Date:	09/09/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	03/16/2015

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 42 year old female with an industrial injury dated 06/05/2013. The mechanism of injury is documented as a fall resulting in left shoulder injury. Her diagnoses included rotator cuff sprain, left, biceps tenosynovitis, left, impingement, left and pain in left shoulder. Prior treatment included therapy, modified activities, home exercise program, and medications. She presents on 02/06/2015 for re-evaluation of a left shoulder condition. Objective findings noted full range of motion of the shoulder with significant positive painful arc. Impingement, Neer, Hawkins, Jobe, Yeragson and Speeds test were positive. There was significant tenderness noted over the subacromial space and lateral bursal shelf as well as over the biceps tendon. The provider documents the following: Her condition has been chronic in nature over 1.5 years with surgery indicated in the past. Her MRI does suggest issues associated with a biceps labral complex type injury. She has had activity limitation for more than 4 months with MRI imaging showing evidence of a surgical lesion. She has failed to improve with appropriate range of motion exercises and therapy. MRI dated 07/05/2013 showed mild supraspinatus and infraspinatus tendinosis without high-grade rotator cuff tear. The formal report is in the submitted records. The treatment plan included left shoulder surgery with associated surgical services to include pre-operative labs and durable medical equipment. The treatment request is for outpatient left shoulder arthroscopy with debridement, possible biceps tenodesis and subacromial decompression, surgical assistant, pre-operative complete blood count, post-operative cold therapy unit rental, post-operative sling, breg exercise kit, and post-operative physical therapy 12 (sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Left Shoulder Arthroscopy with Debridement, possible biceps tenodesis, subacromial decompression QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Shoulder, Indications for Surgery - Acromioplasty.

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: 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 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.

Surgical Assistant QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter, Assistant surgeon.

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

Pre-Operative Complete Blood Count (CBC) QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC; Integrated Treatment/Disability Duration Guidelines, Low Back Chapter, Criteria for lab testing.

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

Post-Operative Cold Therapy Unit Rental QTY: 14 (days): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC; Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter.

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

Post-Operative Sling QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - TWC; Integrated Treatment/Disability Duration Guidelines, Shoulder Chapter, Sling/abduction pillow.

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

Breg Exercise Kit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

Post-Operative Physical Therapy QTY: 12 (sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Physical Therapy Guidelines**.**

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