

Case Number:	CM14-0177319		
Date Assigned:	10/30/2014	Date of Injury:	07/01/2012
Decision Date:	12/08/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/27/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 42 year-old male with a 7/1/12 date of injury. Mechanism of injury was a 6-7 foot fall from a ladder, impacting an asphalt surface flat on his back. An MRI of the left shoulder dated 9/20/13 reportedly showed acromioclavicular osteoarthritis, supraspinatus tendinitis, and infraspinatus tendinitis. The long head of the biceps is maintained in the bicipital groove. MRI arthrogram of the left shoulder dated 2/17/14 was reported to reveal no evidence of contrast extravasation into the subacromial/deltoid bursa to suggest occult full thickness rotator cuff tear. He began physical therapy on 9/17/13, and was in continuous therapy, being discharged on 6/17/14, having completed 4 supervised sessions to his bilateral shoulders and bilateral knees. The patient was most recently seen on 10/10/14 with complaints of constant 7/10 left shoulder pain, with clicking, popping, and weakness. In addition, it is noted that the patient can't sleep over it. Exam findings revealed tenderness over the A-C joint line, and slight left scapular winging. The patient's diagnoses included left shoulder cuff tendinitis rule-out biceps tear. The medications included: Flexeril, Methoderm, Prilosec, Tramadol, zolpidem, Naprosyn/ibuprofen. Significant Diagnostic Tests: MRI, MRI arthrogram. Treatment to date: medications, topical analgesic cream, acupuncture, chiropractic, lumbar support, IF unit, physical therapy, home exercise program. An adverse determination was received on 10/16/14 due to inadequate documentation that the patient had failed conservative care. Moreover, the MRIs did not show a biceps tear or a rotator cuff tear.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopic exploration of the cuff and biceps with possible biceps tenodesis and decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 Chapter

Decision rationale: CA MTUS states that ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively because there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, but is not necessary for function. ODG recommends diagnostic shoulder arthroscopies with inconclusive imaging and continued pain or functional limitation despite conservative care. This patient has been under care for a left shoulder injury that occurred 2 years ago. Despite conservative care in the form of medication, physical therapy, chiropractic, and acupuncture, the patient continued to experience pain, clicking, popping, and weakness in the left shoulder. Physical exam revealed tenderness over the A-C joint, and slight winging of the left scapula. Shoulder ranges of motion and orthopedic testing results were not included in the medical records provided. A 2013 MRI of the left shoulder showed no evidence of a tear of the biceps tendon. A recent MRI arthrogram revealed no evidence of full thickness rotator cuff tear. In a treatment note dated 6/17/14, it was reported that the patient had begun physical therapy on 9/17/13, and was in continuous therapy, being discharged on 6/17/14. However, it further notes that he had completed only 4 supervised sessions, and these were devoted to multiple body parts. This report went on to note that the patient's active range of motion in the bilateral shoulders was within functional limits, and the only functional impairment mentioned was pain with putting on overhead clothing, and placing objects in overhead cabinets. Of note is that the patient consistently rated shoulder pain at 7-8/10. However, no significant functional impairment is documented on physical exam, and the 2 MRI studies fail to demonstrate any rotator cuff or biceps tendon tear that would justify an exploratory, diagnostic surgery. Therefore, the request for Left shoulder arthroscopic exploration of the cuff and biceps with possible tenodesis and decompression is not medically necessary.