

Case Number:	CM14-0144053		
Date Assigned:	09/12/2014	Date of Injury:	08/13/2013
Decision Date:	05/01/2015	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	09/05/2014

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. 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 56 year old, male patient, who sustained an industrial injury on 08/13/2013. A follow up visit dated 06/23/2014, reported a chief complaint of left shoulder pain. His pain radiates anterolateral and into axilla into medial arm. Previous treatment includes; acupressure, massage therapy, applying ice, applying heat, injection therapy, physical therapy and prescription medications. The patient is currently prescribed Vicodin 5/300mg, one every six hours as needed. Objective findings showed left shoulder/arm found Hawkin's, Obrien's, Crank, and Speed testing with positive results. There was a positive impingement sign to the left shoulder. No formal MRI report of the shoulder is noted in the attached records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy vs. mini open biceps tenodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG) indications for surgery-ruptured biceps tendon surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Tenodesis of the long head of the biceps.

Decision rationale: Based upon the CA MTUS Shoulder Chapter pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. According to the Official Disability Guidelines, Tenodesis of long head of biceps include subjective clinical findings including objective clinical findings. In addition there should be imaging findings. Criteria for tenodesis of long head of biceps include a diagnosis of an incomplete tear of the proximal biceps tendon. In this case there is no formal MRI report that demonstrates evidence that the biceps tendon is partially torn or frayed to warrant tenodesis. Therefore the determination is for not medically necessary.

Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-shoulder procedure-continuous-flow cryotherapy.

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.

Post operative physical therapy 2 x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): s 26-27.

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