

Case Number:	CM15-0113136		
Date Assigned:	06/19/2015	Date of Injury:	05/24/2013
Decision Date:	09/10/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/11/2015

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

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 49 year old female who sustained an industrial injury on 05/24/13. Initial complaints and diagnoses are not available. Treatments to date include medications, shoulder injection, and therapy. Diagnostic studies include a MRI and MR Arthrogram of the left shoulder on 05/22/14 demonstrates full thickness supraspinatus tear with some retraction, intact glenoid, biceps anchor and proximal biceps. Current complaints include left shoulder pain. Current diagnoses include left shoulder partial rotator cuff tear, biceps tenosynovitis, and impingement syndrome. In a progress note dated 04/14/15 the treating provider reports the plan of care as left shoulder surgery with associated services. The requested treatments include left shoulder surgery with associated services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy biceps tenodesis: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Criteria for tenodesis of long head of biceps.

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. Criteria for tenodesis of long head of biceps include a diagnosis of an incomplete tear of the proximal biceps tendon. In this case the MRI from 5/22/14 does not demonstrate evidence that the biceps tendon is partially torn or frayed to warrant tenodesis. Therefore the request is not medically necessary.

Pre-operative labs, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Preoperative Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Preoperative testing.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative physical therapy, quantity 12 sessions: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cold Therapy unit for seven 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, Treatment in Workers' Compensation, Shoulder, Acute and Chronic, 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 (ODG) Shoulder, Continuous flow cryotherapy.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Percocet 5/325mg quantity 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.