

<b>Case Number:</b>	CM13-0066581		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	10/15/2013
<b>Decision Date:</b>	03/25/2014	<b>UR Denial Date:</b>	12/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified 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 physician 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 62-year-old female first-grade teacher sustained a right shoulder injury on 10/15/13 when she was struck on the front of the right shoulder. This occurred during a collision with another person was trying to get past her. This resulted in severe right shoulder pain, moderate swelling, and difficulty moving her arm. The 10/26/13 right shoulder MRI showed moderate rotator cuff tendinosis with a non-acute, full-thickness tear at the mid and anterior supraspinatus foot print, yielding variable retraction of the tendon slips and no acute osseous abnormality. Type II acromion was present with mild to moderate acromioclavicular joint arthrosis. The remaining rotator cuff tendons were intact with the rotator cuff muscle bulk preserved. The long head of the biceps tendon was diminutive and not well visualized reflecting chronic tear or degeneration. The 11/18/13 treating physician report cited continued grade 6-7/10 pain globally over the shoulder and at night. The patient was unable to use the arm independently. Some improvement was noted with a TENS unit and physical therapy. Upper extremity exam findings documented no gross deformity or asymmetry, discomfort over the bicipital groove, diffuse periacromial tenderness, near normal passive range of motion, active range of motion compromised due to pain, provocative testing difficult due to pain, pain and weakness with resisted abduction, and positive impingement. Records indicate that the patient has been treated with anti-inflammatories and 12 physical therapy visits. A right shoulder outpatient arthroscopy (OPA) with subacromial decompression and possible bicep tenodesis was recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder OPA. possible bicep tenodesis QTY: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The request under consideration is for right shoulder OPA, possible bicep tenodesis. The ACOEM guidelines apply as the patient was 6 weeks status post injury at the time of the original request. Guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been show to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failed conservative treatment for 3 months. Guidelines state that ruptures of the long head of the biceps tends are usually due to degenerative changes in the tendon and can almost always be managed conservatively. Bicep surgery may be desirable for young bodybuilders but is not necessary for function. There is no documentation that detailed comprehensive conservative treatment for at least 3 months, including injection, has been tried and failed. Given the failure to meet guideline criteria, the request for right shoulder OPA with possible biceps tenodesis is not medically necessary.

**Right Shoulder OPA and SAD. possible bicep tenodesis QTY: 1.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS (2009), Shoulder Complaints, American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2008 Revision), pages 561-563.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The request under consideration is a right shoulder OPA and SAD, possible bicep tenodesis. The ACOEM Guidelines relative to arthroscopic decompression state that conservative care, including cortisone injections, can be carried out for at least 3 to 6 months before considering surgery. Ruptures of the long head of the biceps can almost always be managed conservatively and surgery is reported not necessary for function. This patient was 6 weeks post injury at the time of the surgical request. There is no documentation that detailed comprehensive conservative treatment, including injections, had been tried for at least 3 to 6 months and had failed. Given the failure to meet guideline criteria, this request for right shoulder OPA and SAD, possible bicep tenodesis is non-certified.