

Case Number:	CM14-0129006		
Date Assigned:	08/18/2014	Date of Injury:	04/28/2010
Decision Date:	09/15/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/13/2014

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:

The claimant is a 55-year-old gentleman who was injured on 04/25/10 when he developed left shoulder pain while lifting a patient. The clinical records provided for review include the 07/28/14 assessment noting continued complaints of pain in the shoulder following rotator cuff repair and a decompressive procedure. The assessment did not contain any documentation of physical examination findings. The report of a postoperative MRI dated 03/28/14 revealed supraspinatus tendon repair with a massive re-tear of the tendon with retraction. There was noted to be significant atrophy of the muscle. There was also evidence of prior subacromial decompression and distal clavicle excision. The physical examination findings on 03/04/14 revealed 4/5 motor strength to the shoulder, and zero to 120 degrees of active motion. The records document that postoperative care has included more than 25 sessions of physical therapy, medication management, activity restrictions, and a TENS device. This review is for rotator cuff repair with decompression and an open bicep tenodesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

RCR; arthroscopic coracoid decompression; mini open biceps tenodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation ODG Shoulder Chapter-Surgery for impingement syndrome.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Surgery for ruptured biceps tendon (at the shoulder)Not recommended except as indicated below.

Nonsurgical treatment is usually all that is needed for tears in the proximal biceps tendons (biceps tendon tear at the shoulder). Surgery may be an appropriate treatment option for tears in the distal biceps tendons (biceps tendon tear at the elbow) for patients who need normal arm strength. (Mazzocca, 2008) (Chillemi, 2007) 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, since there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, especially by young body builders, but is not necessary for function. (Rantanen, 1999) When patients having rotator cuff surgery also have a torn biceps tendon, repairing it with tenodesis takes only 10 minutes longer than tenotomy but yields better outcomes. In tenodesis, the surgeon cuts the normal attachment of the biceps tendon on the shoulder socket and reattaches it to the humerus. This maneuver takes pressure off the cartilage rim of the shoulder socket (the labrum), and a portion of the tendon can be resected. The alternative, a tenotomy, simply involves cutting and suturing the tendon. With tenodesis, patients have a longer recovery, but they're also more likely to have better function and a normal appearing biceps muscle. With tenotomy, there can be arm cramping, weakness, and a biceps tendon abnormality called a "Popeye deformity". Tenodesis is a better approach except for the aged, senile, and less active. (Koh, 2010)ODG Indications for Surgery -- Ruptured biceps tendon surgery:Criteria for tenodesis of long head of biceps (Consideration of tenodesis should include the following: Patient should be a young adult; not recommended as an independent stand alone procedure. There must be evidence of an incomplete tear.) with diagnosis of incomplete tear or fraying of the proximal biceps tendon (The diagnosis of fraying is usually identified at the time of acromioplasty or rotator cuff repair so may require retrospective review.):1. Subjective Clinical Findings: Complaint of more than "normal" amount of pain that does not resolve with attempt to use arm. Pain and function fails to follow normal course of recovery. PLUS2. Objective Clinical Findings: Partial thickness tears do not have classical appearance of ruptured muscle. PLUS3. Imaging Clinical Findings: Same as that required to rule out full thickness rotator cuff tear: Conventional x-rays, AP and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.Criteria for tenodesis of long head of biceps with diagnosis of complete tear of the proximal biceps tendon: Surgery almost never considered in full thickness ruptures. Also required: 1. Subjective Clinical Findings: Pain, weakness, and deformity. PLUS 2. Objective Clinical Findings: Classical appearance of ruptured muscle. Criteria for reinsertion of ruptured biceps tendon with diagnosis of distal rupture of the biceps tendon: All should be repaired within 2 to 3 weeks of injury or diagnosis. A diagnosis is made when the physician cannot palpate the insertion of the tendon at the patient's antecubital fossa. Surgery is not indicated if 3 or more months have elapsed. Washington, 2002.

Decision rationale: Based on California ACOEM Guidelines and supported by Official Disability Guidelines, the request for rotator cuff repair; arthroscopic coracoid decompression; mini open biceps tenodesis is not recommended as medically necessary. There is no documentation of recent physical examination findings for review to support the acute need of a revision surgical process. The claimant's MRI scan indicates significant atrophy and retraction of the prior supraspinatus repair with no indication of significant findings of the bicep tendon or physical examination findings of the bicep tendon documented. Without documentation of recent postoperative assessment or indication of bicipital pathology, the acute role of surgical process as requested in this individual with a massive retracted and significantly atrophied rotator cuff would not be supported.