

Case Number:	CM14-0025003		
Date Assigned:	07/11/2014	Date of Injury:	03/30/2010
Decision Date:	08/08/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/27/2014

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:

The claimant is a 57-year-old gentleman injured on March 30, 2010, when he slipped and fell down a flight of stairs while working as a meter reader. The records available for review document multiple diagnoses of the left shoulder, including acromioclavicular joint osteoarthritis and arthrosis with impingement, Superior Labrum Anterior Posterior (SLAP) lesion, subacromial bursitis and rotator cuff syndrome. Conservative treatment has included physical therapy and corticosteroid injections performed in May and September 2010 that were of benefit on a limited basis. An October 2012 left shoulder MRI is referenced in the documents as showing a separation of anterior superior labrum from the glenoid, Superior Labrum Anterior Posterior (SLAP) lesion versus normal variance and current clavicular joint arthrosis with inferior osteophytosis on distal clavicle, indenting surfaces of the supraspinatus. Subacromial bursitis and supraspinatus tenopathy without tear were noted. The report of an MR arthrogram of the left shoulder dated June 5, 2013, showed the following: a tear extending in the superior anterior to antero-posterior quadrants of the labrum and into the biceps; abnormal signal in the proximal portion of the long head of the biceps, most likely due to intrasubstance tears; hypertrophy; a chronic of the good joint narrowing; and downslipping of the acromion. Increased separation was also noted, a new finding compared to the October 2012 study. A progress report dated February 3, 2014, documents complaints of neck and upper back pain with mild numbness and tingling in the upper extremity, inclusive of the arm and hand. The claimant stated that he was not able to sleep on his left shoulder due to pain, which also occasionally interfered with sleep. Pain in the anterior lateral, lateral and posterior regions was described as sharp with certain overhead activities, as well as dull, aching, burning and constant while at rest. The claimant stated that pain interfered with activities of daily living and job duties. Weakness, catching, popping, grinding and loss of motion were also noted. Physical examination showed normal

cervical range of motion and no paracervical muscle or trigger point appreciated. The claimant was tender to palpation on the acromioclavicular joint, greater tuberosity and acromion surface. Reflexes and sensation are noted to be within normal limits. Strength of the left shoulder was documented as 4-/5. The supraspinatous and infraspinatous were otherwise within normal limits. The range of motion demonstrates 170 degrees of forward flexion, 175 degrees of abduction, 45 degrees of abduction, 90 degrees of internal rotation and 90 degrees of external rotation. Passive range of motion was within normal limits. No crepitus was found. The claimant had positive empty-can test, impingement sign, Hawkin's sign, Hawkin's test, Neer testing, biceps load test and cross-arm adduction test. This review request is for a biceps tenotomy and a subpectoral biceps tenodesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Biceps tenotomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation ODG Online Edition, Superior Labrum Anterior Posterior (SLAP) Lesion (<http://www.odg-twc.com/odgtwc/shoulder.htm#Surgery>).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 109-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp; 2013 Updates: Shoulder chapter, Superior Labrum Anterior Posterior (SLAP) Lesion.

Decision rationale: According to California MTUS ACOEM and Official Disability Guidelines, the request for biceps tenotomy would not be medically indicated. ACOEM Guidelines recommend shoulder surgery when there is pathology on imaging, activity limitation for more than four months and appropriate documentation that conservative treatments have failed. The reviewed records reflect prior treatment with physical therapy and injections performed in 2010. However, the records do not specify the anatomical location of the injections or reference any recent, continuous conservative treatment with other measures such as anti-inflammatory medications, activity modification, a home exercise program, recent physical therapy or recent injection. In addition, the request for biceps tenotomy is paired with a request for a tenodesis. It is not clear how the tenotomy and tenodesis could be requested as part of the same surgical intervention. Absent documentation of conservative care and a rationale for the pairing of two procedures. Therefore, the request for Biceps tenotomy is not medically necessary and appropriate.

Subpectoral biceps tenodesis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation ODG Online Edition, Superior Labrum Anterior Posterior (SLAP) Lesion (<http://www.odg-twc.com/odgtwc/shoulder.htm#Surgery>).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Treatment in Worker's Comp; 2013 Updates; Shoulder chapter, Superior Labrum Anterior Posterior (SLAP) Lesion.

Decision rationale: According to California MTUS ACOEM and Official Disability Guidelines, the request for subpectoral biceps tenodesis would not be medically indicated. Guidelines criteria recommend surgery for shoulder pathology following three to six months of conservative treatment. The reviewed records reflect prior treatment with physical therapy and injections performed in 2010. However, as noted in the prior response, the records do not specify the anatomical location of the injections or reference any recent, continuous conservative treatment with other measures such as anti-inflammatory medications, activity modification, a home exercise program, recent physical therapy or recent injection. Also notably, the request for the subpectral biceps tenodesis does not specify the laterality of the procedure; this information would be imperative in any analysis of medical necessity. Finally, the request for biceps tenotomy is paired with a request for a tenodesis. It is not clear how the tenotomy and tenodesis could be part of the same surgical intervention. Absent documentation of conservative care, information on laterality and a rationale for the pairing of two procedures. Therefore, the request for Subpectoral biceps tenodesis is not medically necessary and appropriate.