

<b>Case Number:</b>	CM14-0033073		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	02/09/2012
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	02/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 40-year-old gentleman who was injured in a work related accident on February 9, 2012. Specific to the right shoulder, the records provided for review note that the injury occurred while lifting a large piece of marble. The MRI report of January 27, 2014 identified evidence of supra and infraspinatus tendinosis with bursal side fraying but no rotator cuff tearing. There was also fluid noted along the long head of the biceps tendon and a type II acromion. The PR2 report also dated January 27, 2014 noted ongoing complaints of pain in the shoulder. Physical examination was documented to show weakness with external rotation and abduction and positive impingement findings. The claimant's shoulder was injected with corticosteroid into the subacromial space on that date. Previous conservative treatment has included medication management and therapy. The recommendation was made for right shoulder arthroscopy, rotator cuff repair, subacromial decompression, labral debridement and bicipital "repair".

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RIGHT BICEP REPAIR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 560-561.

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

**Decision rationale:** Based on the California MTUS/ACOEM Guidelines the request for a biceps "repair" in this instance would not be supported. The need for operative intervention to the shoulder has not been supported thus negating this specific portion of the proposed procedure. The request for right bicep repair is not medically necessary and appropriate.

**RIGHT SHOULDER ARTHROSCOPY ROTATOR CUFF REPAIR AND SUBACROMIAL DECOMPRESSION LABRIUM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560-561.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211,214.

**Decision rationale:** Based on California ACOEM Guidelines, surgical intervention to include a rotator cuff repair and subacromial decompression cannot be recommended as medically necessary. In review of the imaging report provided there is no documentation or any evidence of full thickness rotator cuff pathology that would clinically correlate the need for rotator cuff repair procedure. While the claimant's clinical picture is indicative of impingement, the specific surgical request to include subacromial decompression and rotator cuff repair procedure would not be supported. The request for right shoulder arthroscopy rotator cuff repair and subacromial decompression labrium is not medically necessary and appropriate.