

<b>Case Number:</b>	CM14-0038900		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	06/10/2010
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2014

### 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:

This 35-year-old male warehouse manager sustained an industrial injury on 6/10/10. Injury was sustained to his left shoulder and collar bone placing a box in a crate. He underwent left shoulder SLAP repair, rotator cuff repair, and subacromial decompression on 11/12/10. As of 10/4/13, the patient had attended 12 visits of physical therapy for his left shoulder. Left shoulder range of motion was full in flexion and internal rotation with 30 degrees of external rotation and a tight end feel. Strength was grossly 5/5 with external rotation 5-/5 with fatigue. The 11/14/13 left shoulder MRI impression documented postsurgical changes of superior labrum repair without re-tear, mild to moderate cuff tendinosis with no tear, and no strong MRI findings to suggest adhesive capsulitis. The 2/4/14 treating physician report cited left shoulder range of motion improved with forward flexion 160 degrees, external rotation 65-70 degrees, and internal rotation 15 degrees. Left shoulder surgery was recommended for a failed SLAP repair with potential rotator cuff tendon tear. The 3/3/14 treating physician report cited continued pain and discomfort in both shoulders. Physical exam documented moderate crepitus relative to the left shoulder and positive impingement signs relative to the right shoulder. There was diffuse non-specific pain about the base of the neck and interscapular area. The patient had been receiving physical therapy for his neck. Additional physical therapy was recommended focused on posture. Left shoulder surgery was recommended. The 3/17/14 utilization review denied the request for left shoulder arthroscopy and associated services/items based on a clear lack of exhaustion of conservative care and no current quantitative range of motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy, Revision SLAP repair, and Potential Biceps tenotomy V's Tendosis and Rotator Cuff tendon repair.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for SLAP lesion, Surgery for rotator cuff repair, Surgery for biceps tendon rupture.

**Decision rationale:** The California MTUS guidelines do not provide surgical recommendations for chronic injuries. The Official Disability Guidelines (ODG) for surgical repair of SLAP lesions state that SLAP lesions may warrant surgical treatment in certain cases. Guidelines state that arthroscopic repair of SLAP lesions with extensive tears can achieve good outcomes. Surgical intervention may be considered for patients failing conservative treatment. The ODG for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment. Subjective criteria include pain with active arc of motion 90 to 130 degrees and pain at night. Objective criteria include weak or absent abduction and tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of rotator cuff deficit are required. The Official Disability Guidelines state that consideration of biceps tenodesis should include evidence of an incomplete tear with associated subjective/objective clinical findings. Guideline criteria have not been met. There is no documentation of left shoulder painful arc of motion, weakness, or positive impingement tests. There is no evidence of diagnostic or therapeutic injections. Imaging findings do not document labral tear, rotator cuff tear, or biceps deficit. There is no evidence that conservative treatment has been exhausted or failed. Therefore, this request for left shoulder arthroscopy, revision slap repair, and potential biceps tenotomy versus tendosis and rotator cuff tendon repair is not medically necessary.

**Post Operative Physical Therapy 2 x 4 visits.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the request for left shoulder arthroscopy is not medically necessary, the associated request for post-operative physical therapy 2x4 visits is not medically necessary.

**Ultra Sling.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Postoperative abduction pillow sling.

**Decision rationale:** As the request for left shoulder arthroscopy is not medically necessary, the associated request for an Ultra sling is not medically necessary.