

<b>Case Number:</b>	CM14-0055539		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	11/21/2013
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 47-year-old female dental assistant/office manager sustained an industrial injury on 11/21/13. Injury to the right shoulder occurred battling a combative patient. The 2/7/14 right shoulder MRI impression documented small subarticular degenerative cysts in the posterior superior aspect of the humeral head, and no full-thickness rotator cuff tear, retraction, or muscle atrophy. The long head biceps tendon was seen in the groove with intact biceps/superior labral anchor. There was no labral tear and mild subacromial sub deltoid bursitis. There were mild degenerative acromioclavicular joint changes with down sloping acromion and small bone spur reducing the outlet space for the supraspinatus tendon. The 4/2/14 treating physician progress report cited continued right shoulder pain and symptomology. The patient was unable to work. Physical exam documented tenderness over the greater tuberosity and bicipital groove. Right shoulder range of motion included flexion 100, abduction 90, and external rotation 30 degrees with positive impingement testing. The patient was stable to stress testing with normal strength. Pain was noted with resisted infraspinatus and empty can testing. The right shoulder MRI was reviewed. There was mild edema at the acromioclavicular joint with associated subacromial bursitis. There was partial fraying of the acromial side of the supraspinatus. The biceps attachment appeared intact but there was a split tear within the biceps as it traversed the bicipital groove. Surgery was recommended to include subacromial decompression and biceps tenotomy. The 4/17/14 utilization review did not grant the request for right shoulder surgery, pre-operative services as guideline-recommended conservative treatment had not been exhausted, and the MRI report suggested the biceps tendon was intact. The 5/30/14 orthopedic report cited continued very significant localized grade 8/10 pain along the bicipital groove with associated catching and feelings of subluxation. There was very good relief with a bicipital groove injection for 4 days. Conservative treatment had now been exhausted including anti-inflammatories, physical therapy,

and injections. The patient was unable to tolerate continued anti-inflammatories due to gastritis or physical therapy due to pain. Surgery was again requested.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **RIGHT SHOULDER SCOPE, ASAD, LABRAL DEBRIDEMENT, BICEP TENOTOMY, GENERAL ANESTHESIA, PHYSICIAN ASSISTANT: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES/LOW BACK CHAPTER.

**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 impingement syndrome, Surgery for SLAP lesions, Surgery for ruptured biceps tendon Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

**Decision rationale:** The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for acromioplasty generally require 3 to 6 months of conservative treatment, and subjective, objective, and imaging clinical findings consistent with impingement. 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 been met. This patient has now failed a 3 to 6 month trial of guideline-recommended conservative treatment. The orthopedic reading of the MRI showed a split tear of the biceps tendon which is consistent with clinical exam findings of pain, catching, subluxation, and positive diagnostic injection test. Imaging findings are consistent with clinical exam findings of impingement. The Center for Medicare and Medicaid Services (CMS) support the use of a physician assistant for the requested procedures. Therefore, this request for right shoulder scope, subacromial decompression, labral debridement, bicep tenotomy, general anesthesia, and physician assistant is medically necessary.

#### **LAB ORDERS: CBC, CHEM PANEL, PT/PTT, CHEST XRAY, EKG: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES/LOW BACK CHAPTER.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most pre-operative tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Overweight middle-aged females have known occult increased medical and cardiovascular risk factors to support the medical necessity of routine pre-operative screening procedures. Therefore, this request for CBC, Chem panel, PT/PTT, chest x-ray, and EKG is medically necessary.