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| Case Number: | CM14-0058472 | | |
| Date Assigned: | 07/18/2014 | Date of Injury: | 09/13/2009 |
| Decision Date: | 09/18/2014 | UR Denial Date: | 04/10/2014 |
| Priority: | Standard | Application Received: | 04/29/2014 |

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 43-year-old male sustained an industrial injury on 9/13/09. The mechanism of injury was not documented. The patient was status post right shoulder arthroscopic acromioplasty on 1/13/11, and right shoulder arthroscopy with extensive debridement of the glenohumeral joint and subacromial on 8/8/13. The patient reported improvement in right shoulder strength and range of motion in the post-op period with physical therapy. There was continued pain in the proximal biceps region with activity. The patient underwent a subacromial injection without relief. The 12/17/13 right shoulder MRI impression documented a posterior-inferior labral tear with an associated 1 cm labral cyst extending inferiorly. There was a focal full thickness perforation involving the distal supraspinatus tendon, posteriorly. There was an adjacent partial thickness articular surface tear involving the infraspinatus tendon. The 1/8/14 treating physician report cited continued right shoulder pain with activity. Referral to a shoulder specialist was recommended to assess the recent MRI and the relevance of a persistent inferior glenoid cyst. The patient had been unable to return to work. The 3/17/14 consultant report cited diffuse pain over the entire right shoulder that limited overhead reaching. Physical exam documented active forward flexion and abduction of 165 degrees, external rotation 40 degrees, and internal rotation to T7. There was some slight right-sided asymmetry but no dyskinesia. Hawkins's and Neer's tests were positive and Speed's demonstrated pain in the region of the biceps tendon. O'Brien's, Yergason's, and cross body adduction tests were negative. Jobe's testing was 4/5 on the right. Forward flexion strength was 5/5 on the right. MRI findings included a partial thickness bursa sided supraspinatus tendon tear, inferior labral tear on the glenoid with paralabral ganglion, and some mild fluid around the upper aspect of the biceps tendon and biceps groove. The treating physician recommended surgery to evaluate the rotator cuff and labrum, consider partial supraspinatus tendon repair, and biceps tenodesis. The 3/28/14 utilization review denied the

request for right shoulder surgery as there was no overt rotator cuff tear and partial tear may be longstanding. There was no evidence of recent conservative treatment for biceps tendonitis, including bicipital groove injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Surgery, Repair of Partial Supraspinatus Tendon and Biceps Tendonitis: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines; Shoulder Procedure Summary (Updated 12/27/13) Official Disability Guidelines: Indications for Surgery - Rotator Cuff Repair.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Biceps tenodesis.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines recommend biceps tenodesis after 3 months of conservative treatment for Type II SLAP lesions in patient's over 40 years of age or undergoing concomitant rotator cuff repair. Guideline criteria have been met. There is plausible clinical evidence of a SLAP tear which is often associated with an occult proximal biceps lesion. Reasonable non operative treatment appears to have been tried and failed. Therefore the request including at the level of the biceps tendon is medically necessary.