

Case Number:	CM14-0194068		
Date Assigned:	12/01/2014	Date of Injury:	10/20/2012
Decision Date:	01/26/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/18/2014

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 Minnesota. 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 injured worker is a 53-year-old male with a date of injury of 10/20/2012. He was lifting some produce overhead and the load shifted to the left and he sustained a twisting injury to the left shoulder and neck and back. He underwent arthroscopy of the left shoulder with rotator cuff repair and debridement on 7/8/2013. Post-Operatively he developed severe stiffness due to adhesive capsulitis treated with corticosteroid injections and manipulation under anesthesia on 12/9/2013. Per follow-up note of 10/27/2014 he continued to have significant pain in the left shoulder. He was status post left shoulder arthroscopy with limited intra-articular debridement of a labral tear and arthroscopic repair of a small cuff tear on 7/8/13. He developed severe stiffness after his surgery. He had a cortisone injection on 9/10/2013 half into the subacromial space and half into the glenohumeral joint. That gave him some relief from his symptoms but this was not complete. He had a cortisone injection into the biceps tendon sheath on 9/20/2013. This gave him some but not complete relief. He underwent manipulation under anesthesia on 12/9/2013. Since then he has continued to have pain in the left shoulder. Per UR review, an MRI scan of 1/17/2014 showed prior rotator cuff surgery with moderate grade articular sided tearing of the supraspinatus with failure at the footprint, surrounding reactive marrow edema and low grade articular sided tear of the upper tendon of the subscapularis adjacent to the footprint involving 30% of the tendon thickness. He had a final cortisone injection into the shoulder joint on 10/20/2014. This gave him no significant relief. On examination shoulder flexion was 170, abduction 80, internal rotation T12. Strength around the left shoulder was 4-4+/5 in all directions although he had pain on maximum manual testing in all directions. He was tender over the subacromial space and over the biceps tendon. There was no tenderness over the acromioclavicular joint. The impression was resolving stiffness, weakness left shoulder status post rotator cuff repair. He may have an element of bicipital tendinosis. He did have a previous

cortisone injection into the biceps tendon with some relief of symptoms but this was not dramatic. Have some symptoms of ulnar neuritis in the left upper extremity. There was continuing pain and weakness in the left shoulder 15 months post rotator cuff repairs. His most recent MRI showed tendinosis without full-thickness tearing of the supraspinatus tendon. His intraoperative photographs show mild bicipital tendinosis. He has had some improvement to a cortisone injection in the biceps tendon sheath some improvement to a cortisone injection in the subacromial space minimal improvement to a cortisone injection in the joint space itself. He has been advised to undergo further surgery to consist of arthroscopy, biceps tenodesis, and subacromial Bursectomy. A request for this surgery was non-certified by utilization review citing ODG guidelines which state that biceps tenodesis is indicated after 3 months of conservative treatment for type II lesions (fraying and degeneration of the superior labrum, normal biceps, no detachment) had also patient's undergo an uncomplicated rotator cuff repair, history and physical and imaging indicate pathology, and patient is over 40 years old, otherwise consider SLAP repair.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy with Subacromial Bursectomy and Tenodesis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Biceps tenodesis.

Decision rationale: California MTUS guidelines do not address biceps tenodesis as an option for type II or type IV SLAP lesions of the shoulder. ODG guidelines recommend biceps tenodesis as an option for type II or type IV SLAP lesions in patients over 40 years of age after 3 months of conservative treatment with NSAIDs and physical therapy. Type I and type III lesions do not need any treatment or are debrided. The procedure is performed for treatment of biceps tendinitis of the shoulder. It may be performed as part of a larger shoulder surgery such as a rotator cuff repair. The recovery is shorter and the functional outcome is more predictable with a higher rate of satisfaction and return to activity with a biceps tenodesis compared with a biceps repair. The surgery as requested is arthroscopy with Bursectomy and biceps tenodesis. The imaging studies do not show a type II or type IV SLAP lesion per available records. An MRI scan of January 2014 showed recurrent tearing of the rotator cuff per UR review. The MRI report is not submitted. The request for biceps tenodesis does not meet the guidelines and as such the request is not medically necessary.