

<b>Case Number:</b>	CM15-0147911		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	03/17/2015
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 51 year old male with an industrial injury dated 03-17-2015. The injured worker's diagnoses include right shoulder partial rotator cuff tear and superior labral tear. Treatment consisted of Magnetic Resonance Imaging (MRI) of the right upper extremity dated 04-08-2015, physical therapy, anti-inflammatories, injections, and periodic follow up visits. In a progress note dated 06-23-2015, the injured worker presented with right shoulder pain rated 3 out of 10. The injured worker reported temporary improvement from cortisone injection. The injured worker also reported trouble with overhead activity and pain when sleeping on the shoulder. Objective findings revealed restricted right shoulder motion, diffuse tenderness to palpitation, positive Hawkins, positive Neer and positive O'Brien sign. The treatment plan consisted of prescribed medication and right shoulder surgery. The treating physician prescribed services for right shoulder arthroscopy with subacromial decompression and superior labral repair and associated surgical services: pain pump for 48 hours, cold therapy unit for 14 days, and postoperative physical therapy, three times a week for four weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopy with subacromial decompression and superior labral repair:**  
 Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, and 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Topic: Surgery for SLAP lesions.

**Decision rationale:** The injured worker is a 51-year-old male with a date of injury of 3/17/2015. A progress note dated June 23, 2015 indicates that he was having right shoulder pain with a current pain level of 3/10. He had trouble with overhead activity and pain when sleeping on the shoulder. He had received 1 cortisone injection which helped him temporarily. On examination there was diffuse tenderness over the right shoulder. Flexion and abduction was 160 on the right and 180 on the left. Internal and external rotation was 60 on the right and 90 on the left. He had a positive Hawkins, positive Neer and positive O'Brien sign. There was no instability. Motor strength was 5/5 in the abductors and 4/5 in the flexors. Internal and external rotators were also 4/5. The impression was right shoulder partial thickness rotator cuff tear and superior labral tear. The documentation indicates that he had received therapy, nonsteroidal anti-inflammatory drugs, and injections. Arthroscopy was advised. The requested procedure included right shoulder arthroscopy with subacromial decompression and superior labral repair. The MRI scan of the right shoulder dated April 8, 2015 is noted. The impression was severe tendinitis of the supraspinatus tendon with probable calcific tendinitis and partial thickness articular surface tear. There was a SLAP 2 lesion of the superior labrum with a 1 cm para-labral cyst. Biceps tendinitis involving the intra-articular portion of the long head of biceps tendon was noted. Degenerative arthritis of the right acromioclavicular and glenohumeral joints was noted. California MTUS guidelines indicate surgery for impingement syndrome is usually arthroscopic decompression. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. The same is true for partial-thickness rotator cuff tears. 2-3 corticosteroid injections are also recommended as a part of an exercise rehabilitation program prior to surgery. ODG guidelines indicate criteria for surgery for SLAP lesions include 3 months of conservative treatment, type II lesions, type IV lesions, history and physical examination and imaging indicate pathology, and age under 50. For patients over the age of 50 years, biceps tenodesis is recommended. In this case the patient is over 50 years of age. There is evidence of impingement syndrome with a partial thickness rotator cuff tear. There is also evidence of degenerative arthritis of the acromioclavicular and glenohumeral joints. Although arthroscopic subacromial decompression is indicated, ODG guidelines do not support repair of the type II SLAP lesion in individuals over the age of 50 years. The guidelines recommend a biceps tenodesis. As such, the request for the superior labral repair is not supported and the medical necessity of the request has not been substantiated.

**Associated Surgical Service: Pain Pump for 48 hours: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Postoperative Pain Pump.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, and 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Topic: Surgery for SLAP lesions.

**Decision rationale:** Since the primary surgical procedure is not medically necessary, none of the associated surgical services are applicable.

**Associated Surgical Service: Cold Therapy Unit for 14 days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous Flow Cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, and 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Topic: Surgery for SLAP lesions.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postoperative Physical Therapy, three times a week for four weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, 211, and 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Topic: Surgery for SLAP lesions.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.