

<b>Case Number:</b>	CM15-0149714		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	08/04/2014
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	07/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/03/2015

### 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: Illinois, California, Texas

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:

This injured worker is a 47-year-old female who sustained an industrial injury on 8/4/14. Injury occurred when she was shoveling mud out of a driveway. She threw it off to the side and heard a pop in her shoulder, with immediate onset of pain. Conservative treatment included physical therapy, activity modification, and medications. The 1/8/15 right shoulder MRI impression documented complete tear of the long head of the biceps tendon proximally with retraction below the level of the bicipital groove, and fraying/tearing of the superior labrum at the level of the biceps anchor. There was mildly degenerative change of the acromioclavicular (AC) joint and mild lateral downsloping of the acromion, compatible with increased anatomic risk for subacromial impingement, and mild rotator cuff tendinosis with no high-grade rotator cuff tear. The 6/22/15 treating physician report cited right lateral shoulder pain radiating to the lateral aspect of the arm with numbness. There was pain at night and with overhead reaching. She reported catching when lowering the arm from an elevated position, but not with below shoulder level activities. She had attended 6 physical therapy visits and had failed. Medications included Motrin and cyclobenzaprine. Right shoulder exam documented tenderness over the anterior acromion, biceps tendon, anterior joint line and posterior joint line. Shoulder range of motion was flexion 130, abduction 130, extension 30, and external rotation 45 degrees with internal rotation to T10. There was 5/5 muscle strength. Deep tendon reflexes were 2+ and symmetrical over the biceps and brachioradialis, and 1+ and symmetrical over the triceps. Impingement, Hawkin's, Speed's, relocation, and clunk tests were positive. There was pain with abduction. There was trace anterior, posterior, and inferior glenohumeral translation. X-rays showed AC

arthritis and type 2 acromion. Imaging showed a complete tear of the long head of the biceps tendon proximally, fraying/tearing of the superior labrum at the biceps anchor, and mild rotator cuff tendinosis. Authorization was requested for right shoulder arthroscopy with debridement of the torn labrum and post-op physical therapy 3 x 4. The 7/17/15 utilization review non-certified the request for right shoulder arthroscopy with labral debridement as there had been insufficient post-injury physical therapy and surgery was not likely to change her condition. The 8/10/15 treating physician report cited continued right shoulder pain with painful popping. She had failed physical therapy and imaging showed a complete tear of the biceps tendon. Physical exam documented limited range of motion, tenderness about the anterior acromion and greater tuberosity, positive impingement sign, and positive O'Brien's test. The diagnosis was biceps tendon and labral tear right shoulder. Appeal was requested for right shoulder arthroscopy for debridement of the torn labrum. In the interim, additional physical therapy was ordered.

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

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

#### **Right Shoulder Arthroscopy with Debridement of the Torn Labrum: Overturned**

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

**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: Surgery for SLAP lesions.

**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 surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain and catching with overhead activity. Clinical exam findings are consistent with imaging evidence of complete biceps tendon tear, labral pathology, and impingement. Evidence of long-term reasonable and/or comprehensive non-operative treatment and failure has been submitted. Therefore, this request is medically necessary.

#### **Post-op Physical Therapy 3 x 4: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for impingement syndrome suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.