

<b>Case Number:</b>	CM15-0195368		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	12/30/2013
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	10/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: California, Indiana, Oregon  
 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 63 year old male who sustained an industrial injury on 12-30-2013. On 09-10-2014, the injured worker underwent right shoulder rotator cuff repair. According to a progress report dated 02-12-2015, the injured worker was noted to be approximately five months postop right shoulder arthroscopy and rotator cuff repair. He had a biceps tendon rupture on the right as well. He had completed 14 visits of physical therapy for the right shoulder. The provider noted that aggressive physical therapy needed to be continued. Diagnoses included full-thickness rotator cuff tear right shoulder, right shoulder arthroscopy rotator cuff tear and biceps rupture right shoulder. The treatment plan included 8 sessions of physical therapy for the bilateral shoulders. On 04-16-2015, the provider requested and MRI of the right shoulder due to ongoing limitation of motion with pain. On 07-30-2015, pain intensity was rated 5-8 on a scale of 1-10. Pain was made better by rest and worse by overhead reaching. The provider noted that the MRI of the right shoulder demonstrated an intact rotator cuff on the right shoulder with some residual scarring. There was no evidence of full-thickness tearing. The acromion was noted to be flat. The injured worker was noted to have a ruptured biceps tendon with migration distally but this had been noted during the operative procedure. The injured worker received an injection of corticosteroid with lidocaine into the right shoulder. He noted 70% improvement in his pain level with increased shoulder range of motion. He was instructed to work on a home exercise program. According to a progress report dated 09-10-2015, symptoms had recurred. X-rays of the shoulder were performed and demonstrated some mild downsloping of the acromion but without any severe degenerative change. There was no significant abnormality at the AC joint. Objective

findings included right shoulder range of motion 130 degrees flexion, 130 degrees abduction, 75 degrees external rotation. Left shoulder range of motion was 140 degrees flexion, 145 degrees abduction, 85 degrees external rotation. Strength was 5 out of 5 supraspinatus and 5 minus out of 5 bilaterally. Sensation was intact to the bilateral upper extremities. Intact rotator cuff strength was noted. Deep tendon reflexes were diminished bilaterally. The treatment plan included right shoulder arthroscopy with decompression and lysis of adhesions and proximal biceps tenodesis. An authorization request dated 09-28-2015 was submitted for review. The requested services included right shoulder arthroscopy decompression lysis of adhesion with biceps tenodesis, assistant surgeon, cold therapy unit, arm sling and Norco. On 10-05-2015, Utilization Review non-certified the request for right shoulder arthroscopy with decompression, lysis of adhesions, proximal biceps tenodesis, assistant surgeon, associated surgical service: cold therapy unit quantity 7 days and arm sling and Norco 10-325 mg #40.

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

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

#### **Right shoulder arthroscopy with decompression: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case, the worker has had a prior decompression and the post surgical MRI noted the acromion to be flat. As there is no clear surgical lesion, the request is not medically necessary.

#### **Lysis of adhesions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG TWC), Shoulder Chapter; Manipulation under Anesthesia (MUA).

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of surgery for adhesive capsulitis. Per ODG shoulder section, the clinical course of this condition is self-limiting. There

is insufficient literature to support capsular distention, arthroscopic lysis of adhesions/ capsular release or manipulation under anesthesia (MUA). In this case, there is evidence of adhesive capsulitis. The requested procedure is not recommended by the guidelines and therefore is not medically necessary.

**Proximal biceps 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); Treatment in Workers' Compensation (TWC), Shoulder Chapter; Criteria for Tenodesis of long head of biceps..

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of biceps tenodesis. According to the Official Disability Guidelines, Criteria for tenodesis of long head of biceps include subjective clinical findings including objective clinical findings. In addition there should be imaging findings and failure of 3 months of physical therapy. Criteria for tenodesis of long head of biceps include a diagnosis of complete tear of the proximal biceps tendon. In this case, it is not demonstrated on the clinical exams that the ruptured bicep tendon (elected not to treat at prior operation) is responsible for the symptoms. Based on this, the request is not medically necessary.

**Assistant surgeon: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgical service: cold therapy unit (Qty=days) Qty: 7: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Associated surgical service: arm sling: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**Norco 10/325mg #40:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. In this case, there is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity due to medications. Therefore the request is not medically necessary.