

<b>Case Number:</b>	CM15-0197671		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	07/25/2014
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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 61 year old male who sustained an industrial injury on 7-25-2014. A review of medical records indicates the injured worker is being treated for rotator cuff tendinopathy of the left shoulder. Medical records noted pain to the left shoulder. Symptoms are relieved with rest and exacerbated by movement. Pain was rated a 4 out of 10. Physical examination of the left shoulder showed abduction was 180 degrees, forward flexion 180 degrees, extension 40 degrees, adduction 30 degrees, external rotation 90 degrees, and internal rotation 80 degrees. There was tenderness over the coracoacromial arch. There was weakness of the rotator cuff. X-rays dated 5-7-2015 noted no fractures, dislocations, masses, or arthritic changes. He has a type II acromion. Treatment has included 12 sessions of physical therapy without relief, medications, and injection. Utilization review form dated 9-14-2015 noncertified biceps tenodesis, left shoulder abduction pillow, preoperative prothrombin time, and preoperative partial thromboplastin time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy acromioplasty with biceps tenodesis, quantity: 1.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Surgery for SLAP lesions.

**Decision rationale:** Utilization review has certified arthroscopy and acromioplasty. This review pertains to the request for biceps tenodesis. The criteria for surgery for SLAP lesions include type II and type IV lesions after 3 months of conservative treatment including NSAIDs, injections and physical therapy. Surgical repair is indicated for isolated type II lesions and isolated type IV lesions with more than 50 percent of tendon involved in individuals less than 40 years of age. Biceps tenodesis is indicated at age 40 and over. Type I and type III lesions do not require any surgery. In this case the left shoulder X-rays were normal. MRI scan of the left shoulder dated 5/18/2015 revealed an old healed fracture of the distal clavicle. Moderate degenerative changes were noted in the acromioclavicular joint. The supraspinatus tendon was intact. The infraspinatus tendon and teres minor tendons were intact. The subscapularis tendon was intact. There was no rotator cuff muscle atrophy. The long head of biceps tendon was located within the bicipital groove with preserved attachment at the biceps anchor. There was a small tear of the anterior superior labrum. There was a 0.4 times 0.4 cm paralabral cyst associated with the anterior superior labral tear. There was no significant joint effusion. No fluid collection in the subacromial subdeltoid bursa. Progress notes dated 6/19/2015 indicate no change in symptoms. His shoulder pain was rated 2-3/10. Treatment to date had included medication and physical therapy (12 visits approximately). One corticosteroid injection was documented but the result is not known. On examination there was full range of motion. Motor strength was 5/5. O'Brien test was positive. Impingement testing was not documented on this day although it was said to be positive on 5/7/2015. No tenderness over the biceps tendon and a negative Speed's test was documented on prior visits. California MTUS guidelines indicate surgery for impingement syndrome is usually arthroscopic decompression. The procedure is not indicated for patients with mild symptoms or those who have no activity limitations. Conservative care including an exercise rehabilitation program and 2-3 cortisone injections can be carried out for at least 3-6 months before considering surgery. In this case the documentation indicates pain levels of 2-3/10, only 12 physical therapy sessions and one injection have been documented and there is absence of MRI evidence of tendinopathy or impingement. There is a small anterior SLAP lesion documented but an MR arthrogram has not been performed and so it is not known if this is type I, 2, 3, or 4. Type I and type III do not need any surgery or need debridement. Type II requires a biceps tenodesis. If the type IV lesion involves more than 50 percent of the biceps tendon it also requires a biceps tenodesis. The clinical picture is rather benign with absence of any tenderness over the bicipital groove and negative Speed's test. However, the O'Brien test was said to be positive. ODG guidelines necessitate 3 months of physical therapy, corticosteroid injections and NSAIDs prior to surgical considerations for a SLAP lesion (biceps tenodesis). Utilization review has certified the request for arthroscopy with acromioplasty. However, the request for biceps tenodesis is not certified. Based upon the absence of an MR arthrogram demonstrating the need for surgery for the SLAP lesion, the request for the biceps tenodesis is not supported and the medical necessity of the request has not been substantiated. Therefore the request is not medically necessary.

**Associated surgical service: Left shoulder abduction pillow, quantity: 1.00:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Postoperative abduction pillow sling.

**Decision rationale:** With regard to the request for a postoperative abduction pillow sling, ODG guidelines are used. ODG guidelines recommend the postoperative abduction pillow sling as an option after open repair of large and massive rotator cuff tears. It takes the tension off of the repair. The abduction pillow sling is not recommended for arthroscopic shoulder surgery. In this case, there is no rotator cuff tear documented. As such, the medical necessity of the abduction pillow sling has not been established. Therefore the request is not medically necessary.

**Preoperative prothrombin time (PT), quantity: 1.00:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: Preoperative lab testing.

**Decision rationale:** With regard to the request for a preoperative prothrombin time, ODG guidelines are used. The guidelines recommend PT in cases in which there is a history of a bleeding disorder or excessive blood loss is anticipated. In this case, there is no history of a bleeding disorder. The injured worker is undergoing a low risk outpatient procedure. As such, the request for PT is not supported and the medical necessity of the request has not been substantiated. Therefore the request is not medically necessary.

**Preoperative partial thromboplastin time (PTT):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: Preoperative lab testing.

**Decision rationale:** With regard to the request for a preoperative partial thromboplastin time, ODG guidelines are used. The guidelines recommend PTT in cases in which there is a history of a bleeding disorder or excessive blood loss is anticipated. In this case, there is no history of a bleeding disorder. The injured worker is undergoing a low risk outpatient procedure. As such, the request for PTT is not supported and the medical necessity of the request has not been substantiated. Therefore the request is not medically necessary.