

Case Number:	CM15-0030278		
Date Assigned:	02/23/2015	Date of Injury:	04/03/2013
Decision Date:	04/07/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/18/2015

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 45-year-old female, who sustained an industrial injury on April 3, 2013. The diagnoses have included partial tear of rotator cuff, left shoulder involving the subscapularis, and biceps tendinitis. Treatment to date has included surgery on 7/29/2014 consisting of a subacromial decompression and rotator cuff repair, oral pain medications, and physical therapy seven or eight sessions. Currently, the injured worker complains of left shoulder pain. An MR arthrogram did not show a recurrent rotator cuff tear. Mild rotator cuff and possibly biceps tendinosis was noted with mild degeneration of the labrum. In a progress note dated February 2, 2015, the treating provider reports pain with adduction and internal rotation and positive Speed's and lift-off tests. There is a difference of opinion in that the provider notices a full thickness rotator cuff tear of the subscapularis and medial subluxation of the biceps and loosening of the anchor that was not reported by the radiologist. However, two radiology reports including the arthrogram report and the MR report indicate the biceps tendon to be intact and in normal position. The report states "The long head biceps tendon appears normal in position and signal. There may be mild intraarticular long head biceps tendinopathy." There was no leakage of the dye reported that would be expected in a full thickness rotator cuff tear. There was no labral tear reported. On January 29, 2015 Utilization Review non-certified a request for revision surgery for the left shoulder subscapularis repair and biceps tenodesis, noting, the MR arthrogram report was not consistent with a recurrent rotator cuff tear or biceps subluxation. American College of Occupational and Environmental Medicine was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgery- Left Shoulder Subscapular Repair and Bicep Tendosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 560.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211.

Decision rationale: Primary treating physician's permanent and stationary report dated February 2, 2015 indicates IW is status post left shoulder subacromial decompression and rotator cuff repair of 7/29/2014 for partial tear of the subscapularis. An MRI scan was done on 11/7/2014 which showed a full-thickness tear of the upper third of the subscapularis and medial subluxation of the biceps. On examination there was pain with active internal rotation, adduction, positive Speed's and lift off tests. The diagnosis was recurrent rotator cuff tear, biceps tendinopathy. The IW was advised to undergo repeat surgery; however, this was noncertified. MR arthrography dated 11/7/2014 is noted. The impression was 1. Undersurface fraying and tendinopathy is demonstrated of the distal supraspinatus, infraspinatus, and to a lesser degree the subscapularis tendons. 2. Long head biceps tendinopathy with minimal blunting and degeneration of the glenoid labrum 3. No advanced glenohumeral joint degeneration. 4. Mild anatomic impingement related to acromioclavicular joint arthritis. 5. Minimal subacromial subdeltoid bursitis. The report documents good distention of the joint with no evidence of leakage into the subacromial or subdeltoid bursa, mild hypertrophic changes were noted in the acromioclavicular joint with type I or type II acromion. No evidence of a full-thickness rotator cuff tear was appreciated. There was mild subscapularis tendinopathy but no tear. The operative report dated 7/29/2014 indicates that the subscapularis was repaired with a 2 mm fiber tape suture attaching it to a single bio-composite anchor into the lesser tuberosity. The MR arthrography report of 11/7/2014 is not consistent with the primary treating physician's note of February 2, 2015 with regard to a recurrent rotator cuff tear and medial subluxation of the biceps. This is not mentioned in the radiology report. Based upon the radiology report, the surgery as requested for revision rotator cuff repair with biceps tenodesis is not supported as there is no rotator cuff tear documented on the MRI report. The absence of demonstrable leakage of dye through the rotator cuff supports the radiology version of the MR arthrogram. The biceps tenodesis was requested for medial subluxation of the biceps tendon which was also not reported on the MRI. Although the AP may be correct, the radiology interpretation is clearly different. UR used the radiology interpretation for the decision and upon reviewing the entire file there are insufficient grounds to overturn that decision. California MTUS guidelines indicate surgical considerations for a rotator cuff repair in the presence of significant tears on imaging studies. In this case, there is no clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long-term from surgical repair. Furthermore, there is no biceps tendon subluxation documented on the MRI report to support the surgical request for a biceps tenodesis. Only minimal blunting and degeneration of the glenoid labrum is reported. As such, the surgical request for a revision rotator cuff repair and biceps tenodesis is not supported and the medical necessity of the request has not been substantiated.

