

<b>Case Number:</b>	CM15-0056892		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	02/13/2012
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 56-year-old female who sustained a work related injury on February 13, 2012, injuring her neck and left shoulder from repetitive work motions. She was diagnosed with degenerative disc disease and cervical disc protrusions, osteoarthritis of the right shoulder, and carpal tunnel syndrome. Treatment included physical therapy, chiropractic manipulation, acupuncture sessions, epidural steroid injections and pain management. She underwent right cubital tunnel surgery, cervical discectomy, and right shoulder surgery. On 03/11/2015, the injured worker complained of persistent neck pain with radiation into both shoulders; right greater than left. Upon physical examination of the left upper extremity, it was noted that the patient had normal alignment with no asymmetry, crepitus, or effusions; intact range of motion with no dislocations or subluxation, and appropriate muscle tone with no spasticity and no atrophy. Her current medications were noted to include Cymbalta. The treatment plan included AMA impairment, return to work with restrictions and future medical care. A request was submitted for a left shoulder arthroscope, subacromial decompression and open biceps tenodesis; associated surgical service; Ultra sling; postoperative physical therapy for the left shoulder and associated surgical service: Cold compression; however, the rationale was not provided. A Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy, Subacromial Decompression and Open Biceps Tenodesis:**  
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): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome, Biceps tenodesis.

**Decision rationale:** In regards to subacromial decompression, the California MTUS/ACOEM Guidelines state surgery for impingement syndrome is usually arthroscopic decompression. More specifically, the Official Disability Guidelines recommend an acromioplasty after 3-6 months of conservative treatment to include active rehabilitation. There should be evidence of weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain following a diagnostic injection. There should be evidence of impingement on MRI. The clinical documentation submitted for review does not provide evidence the patient has participated in a recent attempt of conservative treatment to include active rehabilitation for at least 3 to 6 months. The clinical documentation does not provide evidence of weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign, and temporary relief of pain following a diagnostic injection. Furthermore, there was no evidence of impingement on MRI, as an MRI was not provided for review of the shoulder. Given the above information, the request is not supported by the guidelines. In regard to the open biceps tenodesis, the California MTUS Guidelines state ruptures of proximal (long head) of biceps tendon are usually due to degenerative changes in the tendon. It can mostly always be managed conservatively, but there is no accompanying functional disability. More specifically, the Official Disability Guidelines state criteria for biceps tenodesis should include 3 months of conservative treatment, type 2 or 4 lesions, and history and physical examination of imaging indicating pathology. Additionally, the guidelines state for over the age of 40, consider SLAP repair. The clinical documentation submitted for review indicated the patient is over the age of 40; therefore, SLAP repair would be considered. However, there is no indication of a recent attempt of conservative treatment for 3 months to include physical therapy. There is no evidence of type 2 or 4 lesions. An official MRI was not provided of the shoulder. Furthermore, history and physical examination did not support pathology. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

**Associated Surgical Service: UltraSling:** 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.

**Post-Operative Physical Therapy (2 times a week for 6 weeks for the left shoulder):** 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 Compression:** 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.