

<b>Case Number:</b>	CM14-0085366		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	02/12/2013
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 51-year-old male who reported an injury on 02/12/2013. The injured worker reportedly suffered a right shoulder strain while loading a fuel truck. The current diagnoses include right shoulder impingement, possible rotator cuff tear, possible labral tear, and adhesive capsulitis. The injured worker presented on 05/15/2014 with complaints of right shoulder pain. Previous conservative treatment is noted to include medication management and physical therapy. It is noted that the injured worker underwent a subscapularis tendon repair, decompression, debridement, and manipulation under anesthesia on 05/01/2013. Physical examination revealed 120 degree forward elevation, 30 degree external rotation, internal rotation at the low lumbar level, moderate tenderness at the greater tuberosity and proximal biceps, 4/5 rotator cuff strength, and mildly positive impingement test. Treatment recommendations included manipulation under anesthesia with arthroscopic lysis of adhesions, decompression and debridement with possible biceps tenotomy or tenodesis. A Request for Authorization form was then submitted on 05/16/2014. It is noted that the injured worker underwent an MRI of the right shoulder on 09/12/2013 which revealed evidence of a previous right subscapularis tendon repair, mild tendinosis of the right supraspinatus and infraspinatus tendons, a previous labral debridement, medial perching of the long head of the biceps tendon, thickening and mild edema in the right inferior glenohumeral joint capsule, and moderate degenerative changes of the right acromioclavicular joint. The injured worker also underwent x-rays of the right shoulder on 05/14/2014 which revealed mild degenerative changes of the AC joint and glenohumeral joint.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Arthroscopy with possible labral repair, Rotator cuff repair, biceps tenodesis, SAD, possible Bicep tenotomy debride manipulate, lysis resect adhesion:** 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): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Bicep Tenodesis

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. Rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation. Surgery for impingement syndrome is usually arthroscopic decompression and is not indicated for those who have no activity limitation. The Official Disability Guidelines state prior to a biceps tenodesis, there should be documentation of at least 3 months of conservative treatment with NSAIDs and physical therapy. The history and physical examination and imaging studies should indicate pathology. As per the documentation submitted, there is no evidence of a rotator cuff tear upon imaging study. The injured worker previously underwent labral debridement on 05/01/2013. Therefore, the injured worker is not currently a suitable candidate for additional labral repair. Based on the clinical information received, the injured worker does not meet criteria for the requested procedure. As such, the request is not medically necessary.

**Surgical assistant:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedics Surgeons Position Statement Reimbursement

**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 a total of 12 sessions:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

**Keflex 500mg #12:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Infectious Disease

**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.

**Zofran 4mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain, Antiemetics for Opioid nausea

**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.

**Ibuprofen 600mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

**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.

**Colace 100mg #10:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Opioid induced constipation

**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 7.5/325 mg #50:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**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.