

<b>Case Number:</b>	CM14-0212561		
<b>Date Assigned:</b>	12/29/2014	<b>Date of Injury:</b>	05/31/2002
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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 63-year-old female who reported injury on 05/31/2002. There was a request for Authorization submitted for review dated 11/25/2014. The injured worker underwent a left shoulder surgery on 03/30/2007. The other surgical history was noncontributory to the request. The injured worker underwent an MR arthrogram of the left shoulder which revealed a partial thickness articular surface tear of the supraspinatus tendon. There was no full thickness rotator cuff tear. There were postoperative changes at the anterior and anterior superior labrum, and there was no evidence of a labral tear. The mechanism of injury included the injured worker lifted an artificial ficus tree and felt a pop in her low back. The documentation of 11/24/2014 revealed the injured worker had bilateral shoulder pain and nocturnal pain. The injured worker had pain with elevation of her arm and the pain affected the injured worker's activities of daily living. The physical examination of the left shoulder revealed global tenderness, pain with impingement maneuvers, empty can, and pain with apprehension test. The injured worker had a positive Yergason's, Speed's, and O'Brien's test. The injured worker had forward flexion of 100 degrees, extension 20 degrees, external rotation of 70 degrees, internal rotation of 20 degrees, and abduction of 95 degrees. The physical exam opined the left shoulder had a significant tear at the supraspinatus and some degenerative changes. The bone morphology was within normal limits and there was an abnormality in the biceps tendon. The diagnoses included bilateral shoulder residual impingement syndrome and possible left rotator cuff tear. The physician documented the treatment plan and discussion included the MRI demonstrated a significant

rotator cuff tear, and the request was made for a left shoulder rotator cuff repair and biceps tenodesis. The medications were noted to include Ultram 50 mg.

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

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

#### **1 left shoulder arthroscopy, biceps tenodesis, and repair of rotator cuff: 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 Indications for Surgery - Rotator cuff repair Official Disability Guidelines; Diagnostic arthroscopy ; Biceps tenodesis: Criteria for Surgery for Biceps tenodesis

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Biceps tenodesis.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates a surgical consultation may be appropriate for injured workers who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. Additionally, they indicate, for partial thickness rotator cuff tears and small full thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative care after 3 months. They do not, however, address biceps tenodesis. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that a biceps tenodesis is recommended for injured workers who have failed 3 months of conservative care and have a type II or type IV lesion. Additionally, it is for injured workers undergoing concomitant rotator cuff repair. The injured worker did have documentation of objective findings upon physical examination which would support the necessity for surgical intervention. The clinical documentation submitted for review failed to indicate the injured worker had exhausted conservative care specifically directed at the shoulder. Additionally, the physician reviewed the MRI documentation and opined the injured worker had a full thickness tear and the official MRI indicated it was a partial thickness tear, which would support the need for conservative care. The decision to perform a biceps tenodesis would be an intraoperative decision. Given the lack of an official reading of a full thickness tear of the rotator cuff, the request for 1 left shoulder arthroscopy, biceps tenodesis, and repair of rotator cuff is not medically necessary.

#### **12 post-op physical therapy 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.

**7 days use of cold therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder (Acute & Chronic) Continuous - flow cryotherapy

**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.

**1 abduction pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Shoulder (Acute & Chronic) ; regarding Postoperative abduction pillow sling

**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.