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| **Case Number:** | CM14-0213412 | | |
| **Date Assigned:** | 12/30/2014 | **Date of Injury:** | 01/07/2011 |
| **Decision Date:** | 02/24/2015 | **UR Denial Date:** | 12/01/2014 |
| **Priority:** | Standard | **Application Received:** | 12/19/2014 |

## 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

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49 year old male with a 1/7/11 injury date. The mechanism of injury was described as preventing a box of merchandise from falling with his right arm. In a 10/15/14 note, the patient complained of 8-9/10 right shoulder pain that increased with above the shoulder activities. Objective findings included tenderness over the lateral deltoid, biceps tendon, acromioclavicular (AC) joint, and acromion. There were positive impingement signs and empty can signs with slightly decreased active range of motion of the right shoulder. A 3/4/11 right shoulder MRI revealed mild subacromial synovitis, a grade I/III partial-thickness tear and tendinosis of the distal subscapularis tendon involving 30% of the tendon thickness, and no evidence of a full-thickness rotator cuff tear or biceps tendon tear. A more recent 1/23/12 right shoulder MRI showed mild AC joint arthritis, infraspinatus tendinosis, and bicipital tenosynovitis. A 6/26/13 QME indicated that, at the very least, shoulder decompressive surgery should be offered. Diagnostic impression: right shoulder impingement syndrome, partial-thickness rotator cuff tear, and biceps tenosynovitis. Treatment to date: physical therapy, medications, and right shoulder injection without relief. A UR decision on 12/8/14 modified the request for right shoulder arthroscopy, subacromial decompression (SAD), possible rotator cuff repair (RCR), and possible biceps tenodesis to allow for right shoulder arthroscopy with SAD only. The rationale for the decision was not available in the documentation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Possible rotator cuff repair & possible biceps tenodesis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter--Rotator cuff repair, Biceps tenotomy/tenodesis.

**Decision rationale:** CA MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, ODG criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. CA MTUS states that ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively because there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, but is not necessary for function. However, there was no evidence of a full-thickness rotator cuff tear on either of the two right shoulder MRI's. Although there was a 30% partial-thickness subscapularis tear in the 2011 MRI, there were no associated objective findings such as a positive lift-off or belly-press test that would necessitate a subscapularis repair surgery. In addition, the 2013 QME provider indicated that the primary issue was impingement, for which an SAD would be a sufficient surgical treatment, and which was approved as part of the recent UR decision. Regarding the biceps tenodesis, there were no objective exam findings such as positive Speed's or Yergeson's tests that would corroborate the 2012 MRI finding of biceps tendonitis. There were no objective functional deficits of the right shoulder that could be attributed to a diagnosis of biceps tenosynovitis. In addition, the evidence-based literature generally does not support routine proximal biceps tendon surgery because there is almost always no accompanying disability. Therefore, the request for possible rotator cuff repair & possible biceps tenodesis is not medically necessary.