

<b>Case Number:</b>	CM15-0112969		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	11/29/2014
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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

### 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 54 year old male, who sustained an industrial injury on 11/29/14. He reported right anterior shoulder pain. The injured worker was diagnosed as having complete rupture of rotator cuff, rotator cuff sprain and strain, and adhesive capsulitis of the shoulder. Treatment to date has included physical therapy and home exercise. Physical examination findings on 5/11/15 included a painful arc of motion abduction greater than forward flexion of the right shoulder. Positive impingement sign and tenderness over the bicipital groove to palpation was noted. A MRI of the right shoulder obtained on 4/7/15 was noted to reveal subacromial impingement with capsulitis with medial subluxation along the biceps tendon, a cephalad tear of the subscapularis tendon with posterior superior labral tear, and a peri labral cyst. Currently, the injured worker complains of right shoulder pain. The treating physician requested authorization for an outpatient arthroscopic decompression, long head biceps tenotomy/tenodesis, subscapularis tendon repair, 12 post-operative physical therapy sessions, a surgical assistant, an x-ray of the right shoulder, and pre-operative labs including electrocardiogram, chest x-ray, and blood labs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient arthroscopic decompression:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for Surgery-Acromioplasty.

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from the exam note of 5/11/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 5/11/15 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.

**Long head biceps tenotomy/tenodesis:** 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), Wheeler's Textbook of Orthopedics, Biceps Tenodesis.

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

**Decision rationale:** CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. In this case there is lack of demonstration of 4 months of activity modification with non-operative treatment to warrant biceps tenotomy and tenodesis. Therefore the determination is not medically necessary.

**Subscapularis tendon repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Repair of the rotator cuff.

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

**Decision rationale:** CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a

clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. In this case there is lack of demonstration of 4 months of activity modification with nonoperative treatment to warrant subscapularis tendon repair. Therefore the determination is not medically necessary.

**12 post-operative physical therapy sessions: 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.

**Pre-operative labs including electrocardiograph (EKG), chest x-ray (CXR) and blood labs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape: Preoperative Testing.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Surgical assistant: 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: X-ray of the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Indications for imaging-Plain radiographs.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.