

<b>Case Number:</b>	CM15-0170252		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	04/26/2013
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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, Oregon, Washington  
 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 40 year old female with an industrial injury dated 04-26-2013. She is being treated for chronic bilateral shoulder impingement syndrome and chronic cervical strain. She was post right shoulder surgery in 12-2013 and left shoulder surgery in "early" 2014. On 05-02-2015 she presented for follow up of chronic pain to both shoulders. According to documentation her left shoulder had not been progressing adequately in postoperative physical therapy. She was using Norco for pain with modest relief and was undergoing cognitive behavioral therapy. She rated her pain as 10 out of 10. Physical exam noted tenderness to palpation of the left anterior and posterior shoulder and acromioclavicular joint. There was decreased active range of motion of the left shoulder which was restricted to less than 90 degrees of abduction and flexion. She was working modified duty (4 hours per day.) 07-22-2015 she presented for reevaluation of her left shoulder. The provider documents the left shoulder was continuing to bother her and she would like to move forward with surgical intervention. Physical findings are documented as exquisite tenderness to palpation over the biceps tendon with positive Hawkins's sign. Supraspinatus strength was 4+-out of 5. The impression documented by the provider was left shoulder rotator cuff repair with residual biceps tendonitis. Prior treatment included oral anti-inflammatories, physical therapy more than 18 visits, two post-operative cortisone injections and medication. The provider documents the injured worker has failed all conservative management. In the note dated 07-22-2015 the provider documents per ultrasound report she does have significant high-grade proximal tear of the long head of the biceps tendon.

MRI arthrogram of left shoulder dated 03-18-2015 noted the following impression: Examination is limited by significant hardware artifact. An articular sided delaminating tear of the infraspinatus is suspected. There is also contrast in the subacromion space, which may be due to a non-water-tight surgical technique. On 08-06-2015 a request for authorization (RFA) was submitted for the following: Left arthroscopic subacromial decompression (SAD), tenodesis of the shoulder, sub pectoral biceps with repairs; Related surgical service: Pre-operative EKG-Related surgical service: Post-operative Sling. On 08-14- 2015 utilization review issued a decision of non-certification for the following: Left arthroscopic subacromial decompression (SAD), tenodesis of the shoulder, sub pectoral biceps with repairs; Related surgical service: Pre-operative EKG-Related surgical service: Post-operative Sling.

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

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

**Left arthroscopic subacromial decompression (SAD), tenodesis of the shoulder, subpectoral biceps with repairs: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Section.

**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 7/22/15. 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 7/22/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the determination is for non-certification, NOT medically necessary.

**Related surgical service: Pre-operative EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.

**Related surgical service: Post-operative Sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.