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| Case Number: | CM13-0014455 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 06/05/2008 |
| Decision Date: | 04/07/2014 | UR Denial Date: | 08/05/2013 |
| Priority: | Standard | Application Received: | 08/21/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Arizona. 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 physician 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:

This patient is a 50-year-old male who sustained a work-related injury on 6/5/08. As a result of his continuing complaints of shoulder pain and limitation of motion secondary to pain and as a result of an MRI scan of the right shoulder; arthroscopic surgery was recommended. The surgery had to be postponed temporarily because of elevation of the patient's blood sugar. On 6/21/11 the patient had arthroscopic surgery with debridement of the labrum and biceps tendon, a subacromial bursectomy and decompression and resection of the coracoacromial ligament. The patient continued to manifest shoulder pain associated with painful limited range of motion. The patient was also complaining of pain in his neck with associated numbness and tingling in the right arm. Electrodiagnostic studies dated 6/25/13 suggested bilateral carpal tunnel syndrome without evidence of cervical radiculopathy. An orthopedic evaluation on 7/1/13 indicated that the patient has had a trial of medication, cortisone injection and physical therapy but has not improved as far as his shoulder pain and limitation of active motion. A recommendation was made for a repeat arthroscopy with labral repair and possible biceps tendon release versus tenodesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 201-211.

Decision rationale: The MTUS guidelines suggest that surgical consultation may be indicated for patients who have red flag conditions e. g., acute rotator cuff tears in a young worker, activity limitations for more than 4 months plus the existence of a surgical lesion, a failure to increase range of motion and strength of muscles around the shoulder plus the existence of a surgical lesion, or a clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. This employee does not have a defined surgical lesion. The radiologist in his interpretation of the MRI scan is giving no more than an educated guess at many of the findings: "Questionable irregularity of the superior glenoid labrum possibly reflecting a SLAP tear", "A partial intrasubstance tear is seen involving a portion of the distal supraspinatus tendon". Intrasubstance tears are no more than internal delamination that cannot be seen on either the superior or inferior surface; it is within the tendon itself and reflects degeneration of the tendon fibers. In addition, the MTUS guidelines indicate that partial tear should be treated the same as impingements regardless of the MRI findings. This employee already had a subacromial decompression and resection of the coracoacromial ligament. Both procedures are done for impingement. As far as the biceps tendon is concerned, the MRI interpretation was "a questionable thickening and signal alteration involving the intra-articular portion of the biceps tendon"; this is not a defined surgical lesion. The imaging studies have failed to reveal a defined surgical lesion which would benefit from arthroscopic surgery. Therefore the medical necessity of a repeat arthroscopic surgery of the shoulder has not been established.

TWELVE (12) SESSIONS OF POST-OP PHYSICAL THERAPY FOR THE RIGHT SHOULDER: 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. Additionally, the employee had physical therapy after the first arthroscopic surgery and it did no good in increasing range of motion or relieving pain.

DME: THERMACOOLER SYSTEM FOR THE RIGHT SHOULDER: 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.