

Case Number:	CM14-0215637		
Date Assigned:	01/05/2015	Date of Injury:	12/10/2013
Decision Date:	02/28/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/23/2014

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: Minnesota, Florida
 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 39-year-old male with date of injury of 12/10/2013. Per progress notes dated 12/11/2013 he sustained a laceration of the right hand while he was cutting marble. The laceration involved the extensor tendon to the middle finger. Examination revealed a 4-5 cm laceration that had been repaired with sutures. He was unable to extend the right middle finger. He underwent surgical repair on 12/16/2013. Both the capsule and tendon were repaired. Thereafter he received 10 physical therapy sessions and was instructed in a home exercise program with theraputty and therabands. He had residual pain and limitation of strength in his hand as well as range of motion. On 6/1/2014 he was at work polishing a stone with a machine repeatedly above the shoulder level. When he returned home that night he had pain in the right shoulder. He told his employer and was first seen for this problem on 8/5/2014. He was treated with physical therapy and Tylenol. He had an MRI scan of the right shoulder on 8/29/2014. This was reported to show mild to moderate rotator cuff tendinosis with subdeltoid bursitis without full-thickness tear or retraction with downsloping acromion and an os acromiale and acromioclavicular joint degenerative change. SLAP lesion was seen extending to but not avulsing the biceps anchor, extending to the posterior mid labrum with a para-labral cyst formation. This measured 2.1 x 2.9 x 1.8 cm with subjacent superior glenoid minimal edema and cystic change. There was lateral downsloping of the acromion with an os acromiale and acromioclavicular joint degenerative change. Moderate tendinosis was seen in the rotator cuff but there was no full-thickness tear or retraction. The superior labrum was normal in signal intensity and configuration extending anterior to posterior consistent with a SLAP lesion which

extended to but did not avulse the biceps anchor with posterior superior paralabral cyst formation measuring up to 2.1 cm x 2.9 cm x 1.8 cm. The biceps tendon was situated within the bicipital groove. The anchor was involved by the SLAP lesion but not avulsed. He had chronic neck and back pain and was treated with chiropractic manipulation. An orthopedic consultation was obtained on 10/30/2014 for the right shoulder. Examination of the right shoulder revealed tenderness in the bicipital groove, subacromial space, acromioclavicular joint, positive Neer and Hawkins impingement sign, positive Speed's, positive O'Brien's, and pain with circumduction. Forward flexion was 140, abduction 120 with discomfort, adduction 90, external rotation 80, internal rotation 20. Documentation indicates that he had approximately 15 visits of physical therapy for his shoulder. Arthroscopy of the right shoulder was advised with subacromial decompression, debridement and probable open biceps tenodesis. The request was noncertified by utilization review citing guidelines that indicate 3-6 months of conservative treatment for impingement syndrome prior to surgical considerations. Documentation indicated no problems with activities of daily living. Physical therapy notes indicate an initial evaluation on 10/6/2014 for neck pain, lumbar pain, and the right shoulder and hand. The requested surgery was noncertified because after the 15 physical therapy visits the additional 9 sessions were not directed to the right shoulder. Guidelines do not recommend surgery for impingement syndrome for patients with mild symptoms or those with without activity limitations. Although he worked modified duty, activities of daily living were all intact. Motor and sensory testing was normal. The denial was appealed to an independent medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 right shoulder arthroscopy, subacromial decompression, debridement and probable open 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), Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months plus existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, 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. The available documentation indicates the presence of impingement syndrome but no rotator cuff tear. Surgery for impingement syndrome is usually arthroscopic decompression. However, it is not indicated for mild symptoms or those with no activity limitations. Conservative care including cortisone injections and an exercise program should be carried out for 3-6 months before considering surgery. 2-3 cortisone injections are recommended as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome or small tears. The documentation does not support such a rehabilitation program. The documentation also indicates absence of any

difficulty with activities of daily living indicating relatively mild symptoms. In light of the above, the request for arthroscopy of the right shoulder with subacromial decompression and open biceps tenodesis is not supported by guidelines and as such, the medical necessity of this request is not substantiated.

Associated surgical service: 1 assistant surgeon: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Centers for Medicare & Medicaid Services (CMS), Physician fee schedule search, CPT Code 23130 <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The surgery is not medically necessary. Therefore the assistant surgeon is not needed.

Associated surgical service: Unknown post-op physical therapy visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, and 213.

Decision rationale: The surgery is not medically necessary. Therefore the post-op physical therapy is also not medically necessary.

Associated surgical service: 1 cold therapy unit: 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), Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 210, 211, 213.

Decision rationale: The surgery is not medically necessary. Therefore the post-operative cold therapy is not applicable.