

Case Number:	CM13-0000874		
Date Assigned:	02/28/2014	Date of Injury:	02/18/2013
Decision Date:	06/10/2014	UR Denial Date:	06/19/2013
Priority:	Standard	Application Received:	06/28/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/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:

The patient is a 47 year old male who was injured on 02/18/2013 while pushing up a very heavy gate which caused severe painful cracking, popping sound in his right shoulder. Prior treatment history has included x-rays that indicated shoulder dislocation with subsequent reduction of the dislocation. He has received therapy two times a week as well as getting electrical stimulation and hot packs but to this date has not relieved his shoulder pain. His medications include acetaminophen, Naprosyn and pantoprazole. Diagnostic studies reviewed include right shoulder injection for MR arthrogram dated 06/03/2013. MRI of the right shoulder post joint injection dated 06/03/2013 with the following impression: 1) Old Hill Sachs deformity and anterior labral tear. 2) Tear of the superior labrum without tear of attachment of the tendon for long head of biceps. EMG and NCV study dated 12/24/2013 reveals evidence of a moderate bilateral carpal tunnel syndrome (median and nerve compartment at wrist) affecting sensory and motor components. Also reveals evidence of mild acute L5 radiculopathy on the right. Initial physical therapy evaluation dated 03/25/2013 documented the patient to have complaints of difficulty to perform ADLs due to right shoulder pain. Objective findings on exam included diffuse tenderness to palpation of the right shoulder area. Shoulder active range of motion (right) revealed: flexion 100 degrees, 3/5 gross strength, extension 25 degrees, 3/6 gross strength, abduction 90 degrees, 2/+5 gross strength, internal rotation 45 degrees, gross strength 2/5 and external rotation 45 degrees, gross strength 2/5. There was diffuse tenderness to palpation of right shoulder area. Physical therapy daily note dated 04/01/2012 documented the patient with complaints of difficulty in sleeping due to shoulder pain. Assessment: Patient was not able to perform any therapy exercises due to 9/10 pain level. Physical therapy daily note dated 04/03/2013 documents the patient reports a decrease in symptoms since his last visit. Assessment: Patient was able to start AROM. Progress noted dated 04/04/2013 documented

patient with complaints of right shoulder pain. Objective findings on examination included on musculoskeletal exam the patient denies stiffness, swelling, muscle weakness and myalgias. He is able to actively forward flex and abduct to approximately 120 degrees. He internally rotates to T10 and is able to externally rotate to approximately 70 degrees. His sensory exam is within normal limits in the axillary and ulnar nerve distributions but has some decreased sensation to light touch in knee superficial radial and median nerve distributions distally in his hand. His motor exam is within normal limits in the EPL, FLP, EDC, FDS, FDP, and intrinsic muscles of the hand. His hand is warm and well perfused. Physical therapy daily note dated 04/08/2013 documented the patient with complaints of difficulty sleeping due to shoulder pain. Assessment: Patient had difficulty with completion of exercise, secondary to pain levels. Physical therapy daily note dated 04/08/2013 documented the patient reporting a decrease of symptoms since last visit. Assessment: Tolerated with decreased symptoms and increased function. Physical therapy daily note dated 04/08/2013 documented the patient with complaints of difficulty sleeping due to shoulder pain and also complaint of numbness in his right upper extremity. Assessment: Tolerated with decreased symptoms and increased function. Physical therapy daily note dated 04/10/2013 documented the patient with complaints of difficulty sleeping due to shoulder pain. Assessment: Patient had difficulty with completion of exercise, secondary to pain level. Progress note dated 05/07/2013 documented the patient with complaints of right shoulder pain. Objective findings on exam included examination of the musculoskeletal region which the patient denied stiffness, swelling, muscle weakness and myalgias. He is able to actively forward flex and abduct to approximately 120 degrees. He internally rotates to T10 and is able to externally rotate to approximately 70 degrees. His sensory exam is within normal limits in the axillary and ulnar nerve distributions but has some decreased sensation to light touch knee superficial radial and median nerve distributions distally in his hand. His motor exam is within normal limits in the EPL, FPL, EDC, FDS, FDP and intrinsic muscles of the hand. His hand is well perfused and warm. Progress note dated 06/11/2013 documented the patient with complaints of right shoulder pain. It is described as aching, constant, dull, sharp, tenderness, throbbing, and worsening. The patient denied stiffness, swelling, muscle weakness and myalgia.

The complaint moderately limits activities, difficulty raising arm, lacks active range of motion and lacks strength. On objective findings examination revealed he is actively able to forward flex and abduct to approximately 120 degrees. He internally rotates to T10 and is able to externally rotate approximately 70 degrees. His sensory exam is within normal limits in the axillary and ulnar nerve distributions but has some decreased sensation to light touch knee superficial radial and median nerve distributions distally in his hand. His motor exam is within normal limits in the EPL, FPL, EDC, FDS, FDP and intrinsic muscles of the hand. His hand is well perfused and warm.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARTHROSCOPY, SHOULDER, SURGICAL; DEBRIDEMENT: Overturned

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, surgery for SLAP lesions.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): (s) 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for SLAP lesion.

Decision rationale: The patient's 06/03/2013 MR Arthrogram of the right shoulder revealed an Old Hill Sachs deformity and anterior labral tear; tear of the superior labrum without tear or attachment of the tendon for long head of biceps. He presents with persistent pain and functional loss of strength and range of motion, despite conservative measures that has included NSAID and physical therapy. The medical record document the existense of surgical lesion in the right shoulder and failure to respond to non-invasive measures. At this point, it is not anticipated that further conserviative care would be efficacious. According to the referenced guidelines, debridement is the recommended surgical intervention for type I SLAP lesions. The medical records establish the patient is a candidate for the proposed surgical intervention. Request is medically necessary.