

Case Number:	CM13-0050486		
Date Assigned:	02/21/2014	Date of Injury:	03/18/2005
Decision Date:	09/08/2014	UR Denial Date:	10/24/2013
Priority:	Standard	Application Received:	11/13/2013

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 claimant is a 57-year-old who was injured on March 18, 2005. Medical records provided for review document ongoing complaints of pain in the left shoulder and left wrist. The office note dated August 14, 2008 noted continued complaints of pain in the shoulder and left wrist with radiating pain and weakness to the left hand. The report of radiographs of the left wrist were negative. The report of radiographs of the left shoulder showed moderate widening of the acromioclavicular joint. Physical examination showed restricted shoulder range of motion with positive Speed's, Hawkin's, and Neer testing. There was also positive Yergason's testing. There was noted tenderness about the bicipital groove and the acromioclavicular joint with palpation. Examination specific to the left wrist demonstrated restricted range of motion with tenderness over the left ulnar styloid and swelling of the volar surface. There was no additional imaging reports of the claimant's shoulder or wrist noted. Based on failed conservative care the recommendation was made for left shoulder arthroscopic subacromial decompression with possible rotator cuff/labral repair. A second request was also made for left wrist arthroscopy with debridement and possible repair of the TFCC.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPIC SURGERY WITH SUBACROMIAL DECOMPRESSION WITH POSSIBLE ROTATOR CUFF LABRAL REPAIR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

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

Decision rationale: Based on the Shoulder Complaints Chapter of the ACOEM Practice Guidelines the request for left shoulder arthroscopic surgery with subacromial decompression and possible rotator cuff labral repair is not recommended as medically necessary. ACOEM Guidelines recommend prior to surgery for impingement that six months of conservative care with injections be provided prior to proceeding with operative intervention. Records in this case fail to demonstrate recent Corticosteroid injections. The medical records also do not contain any imaging reports of the shoulder that would require decompression, rotator cuff or labral procedures. Based on the above the request for surgical intervention to the left shoulder would not be indicated. The request for left shoulder arthroscopic surgery with subacromial decompression with possible rotator cuff labral repair is not medically necessary or appropriate.

LEFT WRIST ARTHROSCOPY WITH DEBRIDEMENT SYNOVECTOMY POSSIBLE REPAIR OF THE TFCC: 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), FOREARM, WRIST & HAND, TRIANGULAR FIBROCARILAGE COMPLEX (TFCC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

Decision rationale: The Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines do not support the request for left wrist arthroscopy with debridement, synovectomy, and possible repair of the TFCC. The Forearm, Wrist, and Hand Complaints Chapter of the ACOEM Practice Guidelines recommend clear clinical and special study evidence of lesion has been shown to benefit in both the short and long term from surgical intervention before proceeding with operative procedure. Records in this case fail to demonstrate any injury to the TFCC or the wrist that would require an arthroscopy or TFCC repair. Given information above including no documentation of recent conservative measures, the specific surgical request would not be supported. The request for Left wrist arthroscopy with debridement synovectomy possible repair of the TFCC is not medically necessary or appropriate.