

Case Number:	CM13-0066055		
Date Assigned:	01/03/2014	Date of Injury:	04/11/2009
Decision Date:	06/25/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	12/16/2013

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 an employee of [REDACTED] and has submitted a claim for left shoulder impingement syndrome with bursitis and tendinitis, traumatic impingement syndrome of the right shoulder with complete tear of the rotator cuff, bilateral carpal tunnel syndrome, lumbar spine sprain/strain, and internal derangement of both knees associated with an industrial injury date of April 11, 2009. Treatment to date has included right shoulder arthroscopic surgery on March 12, 2013, lumbar epidural steroid injection, physical therapy, chiropractic care, acupuncture, and medications such as gabapentin, hydrocodone/apap, Ultram, Anaprox, and Prilosec. Utilization review from November 6, 2013 denied the request for left shoulder arthroscopic surgery and decompression due to lack of documentation on the total number of previous therapy visits and its outcome. There was likewise no imaging for review. Medical records from 2011 to 2013 were reviewed showing that patient complained of pain at cervical spine, left shoulder, bilateral wrists, lumbosacral spine, and bilateral knees graded 6-7/10 in severity. He likewise complained of tingling and numbness in both hands much worse at night. This resulted to difficulty with lifting, pushing, pulling, gripping, and grasping activities. Bilateral knee pain was aggravated with prolonged standing, repetitive kneeling and squatting activities. The patient was not able to work at or above the shoulder level. Physical examination showed tenderness at cervical spine, volar aspect of bilateral wrists, lumbosacral spine, and bilateral knees. Subacromial crepitation was noted at the left shoulder. Range of motion of cervical spine, lumbosacral spine and both knees was restricted. Range of motion of the left shoulder was limited towards flexion and abduction. Phalen's and Tinel's tests were positive bilaterally. EMG/NCV of cervical spine and bilateral upper extremities, dated August 20, 2013, revealed no electrical evidence of cervical radiculopathy or any focal peripheral nerve compression.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ARTHROSCOPIC SURGERY AND DECOMPRESSION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, , 561-563

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

Decision rationale: The California MTUS reference to ACOEM indicates that arthroscopic surgery and decompression for the shoulder may be considered reasonable and necessary if there is activity limitation for more than 4 months, 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. In this case, the rationale given for this surgery is because patient has not shown subjective and objective improvement, as well as functional restoration of work ability even after conservative care. It is unclear whether the patient has received steroid injections in the past and total number of visits to physical therapy is likewise not documented. A report dated August 13, 2013 cited that there was MRI evidence of tendinitis and bursitis of the left shoulder. However, the official MRI result is not found in the documents submitted for review. The guideline criteria have not been met. Therefore, the request for left shoulder arthroscopic surgery and decompression is not medically necessary.