

<b>Case Number:</b>	CM14-0005862		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	05/12/2013
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management 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 48 year-old female who has filed a claim for shoulder impingement syndrome associated with an industrial injury date of May 12, 2013. A Review of progress notes reports bilateral upper extremity symptoms, left more than right. There was bilateral shoulder pain radiating to the left side of the neck, and difficulty reaching up with the left arm. Patient reported minor numbness and weakness in bilateral arms. Findings include tenderness of the anterior shoulder regions bilaterally, and left posterior shoulder. There was positive impingement sign on the right. Regarding the wrists, Phalen's test was positive bilaterally. Right shoulder MRI dated November 29, 2013 showed full-thickness and near complete tear of the supraspinatus tendon, partial articular surface tear of the infraspinatus tendon, and degenerative changes within the AC joint with subacromial osteophytosis and increased risk for impingement. Left shoulder MRI showed full-thickness and complete tear of the supraspinatus tendon with a gap of 3cm, moderate AC joint degenerative changes with subacromial osteophytosis and increased risk of impingement, and tendinopathy changes of the infraspinatus tendon. EMG/NCS dated December 03, 2013 showed moderate carpal tunnel syndrome of the bilateral upper extremities. Patient is currently working regular duty. The treatment to date has included NSAIDs, ice and heat, steroid injections to the right and left shoulder, and physical therapy. A utilization review from December 31, 2013 denied the request for carpal tunnel release of the left wrist and post-op physical therapy for the left wrist 2x3 as there is no documentation that this patient had conservative treatment. There is modified certification for post-op vascultherm cold therapy for left shoulder x 7 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CARPAL TUNNEL RELEASE OF LEFT WRIST: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome chapter, Carpal tunnel release surgery (CTR).

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, carpal tunnel release surgery is recommended after an accurate diagnosis of moderate to severe carpal tunnel syndrome. For severe carpal tunnel syndrome, indications include muscle atrophy and severe weakness of the thenar muscles, two-point discrimination test > 6 mm, and positive electrodiagnostic testing. For other cases, indications include symptoms - nocturnal symptoms, flick sign, abnormal Katz hand diagram scores; at least two of the following - compression test, Semmes-Weinstein monofilament test, Phalen sign, Tinel's sign, decreased 2-point discrimination, or mild thenar weakness; initial conservative treatment, at least 3 of the following - activity modification > 1 month, night wrist splinting > 1 month, analgesic medications, home exercise training, or successful outcome from corticosteroid injection trial; and positive electrodiagnostic testing. In this case, a report dated January 17, 2014 indicates that the patient does not wish to have surgery at this point. There is electrodiagnostic evidence of moderate carpal tunnel syndrome, but there is no documentation regarding conservative management strategies such as wrist splinting. Therefore, the request for carpal tunnel release of the left wrist was not medically necessary.

**POSTOPERATIVE COLD THERAPY FOR LEFT SHOULDER X 10 DAYS: 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 chapter, Cold compressoin therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Cold compressoin therapy.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, cold compression therapy is not recommended in the shoulder, as there are no published studies. In this case, a report dated January 17, 2014 indicates that the patient does not wish to have surgery at this point, although the surgery to the left shoulder was authorized. Also, this modality is not recommended for the shoulder. Therefore, the request for post-operative cold therapy for the left shoulder x 10 days was not medically necessary.

**POSTOPERATIVE PHYSICAL THERAPY FOR LEFT WRIST 2 TIMES A WEEK FOR 3 WEEKS:** 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, the associated services are medically necessary.