

Case Number:	CM14-0009072		
Date Assigned:	02/12/2014	Date of Injury:	12/27/2006
Decision Date:	06/24/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/23/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Sports Medicine, and is licensed to practice in Pennsylvania. 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 54-year-old gentleman who sustained an injury to the wrist and shoulder of the left upper extremity on December 27, 2006. The records provided for review include an operative report indicating left shoulder surgery and subacromial decompression in November 2009 followed by an April 2010 manipulation under anesthesia. The report of the January 28, 2014 follow up visit noted continued complaints of pain in the left shoulder and left wrist for the diagnosis of rotator cuff tear and carpal tunnel syndrome. The report documented complaints of weakness and numbness of the upper extremity and examination showed a positive Neer's, Hawkins' and Jobe's testing, and paresthesias to the digits and loss of shoulder range of motion. The report of a June 24, 2013 left shoulder MRI (magnetic resonance imaging) showed postsurgical changes consistent with a prior acromioplasty, distal clavicle resection and SLAP repair. There was also indication of a prior rotator cuff repair with no residual recurrent or full thickness pathology noted. There was also evidence of prior biceps tenodesis with subacromial bursitis and no revision SLAP lesion. This is a request for revision left shoulder subacromial decompression and rotator cuff procedure with a left wrist carpal tunnel release and twelve sessions of postoperative physical therapy. The records did not contain prior or recent electrodiagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER ROTATOR CUFF DECOMPRESSION, REPEAT PROCEDURE:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Based on California ACOEM Guidelines, left shoulder rotator cuff surgery and subacromial decompression would not be supported. The medical records do not confirm recurrent rotator cuff pathology noted on recent imaging. There is also no indication of recent conservative care including injection therapy that has been documented and is recommended by ACOEM Guidelines before proceeding with surgery. As such, the request is not certified.

LEFT CARPAL TUNNEL RELEASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, 270.

Decision rationale: The California ACOEM Guidelines cannot support the request for left carpal release. While this individual is noted to have complaints of paresthesias on recent examination, there is no report of electrodiagnostic studies to confirm or refute a diagnosis of carpal tunnel syndrome. Therefore, surgery cannot be supported in accordance with ACOEM Guidelines.

POST-OPERATION PHYSICAL THERAPY 2 TIMES A WEEK FOR SIX: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The proposed left shoulder rotator cuff decompression and left carpal tunnel release cannot be recommended as medically necessary. Therefore, the request for postoperative physical therapy is not necessary.