

Case Number:	CM14-0068162		
Date Assigned:	07/11/2014	Date of Injury:	09/25/2008
Decision Date:	08/14/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/12/2014

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; 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:

This 57-year-old male cook/cleaning supervisor sustained an industrial injury on 9/25/08, relative to a slip and fall. Past medical history was positive for a right shoulder injury in 1994 when he slipped and fell, dislocating the shoulder. In 1995/1996, he fell off a ladder and injured his right elbow. The 3/17/10 right shoulder MRI impression documented mild to intermediate grade undersurface supraspinatus tear, massive hypertrophy of the acromioclavicular joint, and mild articular subscapularis tearing with splitting of the biceps tendon in the upper groove and tendinosis distally. There was a small ossific fragment avulsed likely from the lesser tuberosity. The 12/13/10 upper extremity EMG /NCV ((Electromyogram/ Nerve conduction velocity) findings documented mild bilateral carpal tunnel syndrome, right ulnar neuropathy at the elbow and wrist, mild left ulnar neuropathy at the elbow, and axonal polyneuropathy. The 3/6/14 orthopedic report cited unchanged neck, upper back, right ankle, right elbow, and bilateral shoulder, arm, wrist, and hand pain. Exam findings documented light touch intact over the bilateral shoulder and fingers. The treatment plan recommended right shoulder arthroscopy and right ulnar nerve decompression and medial epicondylectomy. The 4/14/14 utilization review denied the requests for right shoulder and elbow surgery based on a lack of adequate detail relative to either elbow or shoulder findings to base consideration of surgical intervention. The 4/16/14 AME (Agreed Medical Evaluation) report cited multiple complaints including bilateral shoulder and right elbow pain. Right shoulder pain was reported constant with a sensation of weakness, giving way, clicking and popping. Right elbow pain was reported intermittent with weakness, clicking and popping. Right shoulder exam documented mild loss in range of motion, no shoulder girdle atrophy, no ligamentous laxity or evidence of instability, and negative drop arm test bilaterally. Impingement tests were positive on the right. Pain was reported at extremes of motion. Right shoulder abduction, flexion, and internal rotation strength was 4/5. Right elbow

exam documented medial and lateral right elbow tenderness, no swelling or effusion, and slight loss of elbow flexion. There was pain at extremes of motion. Tinel's was positive on the right with pain and tingling in the 4th and 5th fingers. Right elbow strength was 5/5. There was decreased sensation over the right thumb, index and part of the middle finger and over the ulnar border of the right forearm and hand. The 4/16/14 right shoulder x-rays demonstrated a Type II acromion. The AME recommended right shoulder arthroscopy with subacromial decompression, assessment of rotator cuff and repair if necessary. Relative to the right elbow, additional conservative treatment should include injections and splints prior to surgical consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. Guideline criteria have been met. This patient presents with subjective and objective clinical exam findings of impingement, consistent with imaging. The patient has failed long-term conservative treatment. There is documented constant pain with weakness, giving way, clicking, popping, and functional impairment. Therefore, this request for right shoulder arthroscopy is medically necessary.

Right ulnar nerve decompression and medial epicondylectomy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36-38.

Decision rationale: The California MTUS guidelines state that surgery for ulnar nerve entrapment requires establishing a firm diagnosis on the basis of clear clinical evidence and positive electrical studies that correlate with clinical findings. A decision to operate requires significant loss of function, as reflected in significant activity limitations due to the nerve entrapment and that the patient has failed conservative care, including full compliance in therapy, use of elbow pads, removing opportunities to rest the elbow on the ulnar groove,

workstation changes (if applicable), and avoiding nerve irritation at night by preventing prolonged elbow flexion while sleeping. Absent findings of severe neuropathy such as muscle wasting, at least 3-6 months of conservative care should precede a decision to operate. Guidelines do not typically recommend medial epicondylectomy for ulnar neuropathy. Guideline criteria have not been met. There is Electrodiagnostic and clinical evidence of right ulnar nerve entrapment. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. Therefore, this request for right ulnar nerve decompression and medial epicondylectomy is not medically necessary.