

Case Number:	CM15-0040819		
Date Assigned:	03/11/2015	Date of Injury:	05/06/2013
Decision Date:	04/22/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/03/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Orthopedic Surgery

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 44 year old male sustained an industrial injury after being electrocuted and landing on his left side on 5/6/13. The injured worker complained of ongoing neck and left upper extremity pain. In a PR-2 dated 2/2/15, the injured worker complained of left shoulder pain with radiation to the head, neck, arm, hand, fingers and back associated with swelling, clicking, locking, burning, tingling, stiffness, weakness and numbness. Pain was rated 7/10 on the visual analog scale. Physical exam was remarkable for left shoulder subacromial tenderness with positive impingement and left hand with decreased sensation to thumb, index and long finger. Current diagnoses included status post electrocution to the left upper extremity, status post mechanical fall, left shoulder sprain/strain with tendinitis and impingement, lumbar spine sprain/strain with lower extremity radiculopathy, cervical spine sprain/strain, and mild bilateral carpal tunnel syndrome. The treatment plan included left shoulder scope with debridement and SAD and left carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder scope with debridement and SAD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Acromioplasty surgery.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. The ODG shoulder section, acromioplasty surgery recommends 3-6 months of conservative care plus a painful arc of motion from 90-130 degrees that is not present in the submitted clinical information from 2/2/15. In addition night pain and weak or absent abduction must be present. There must be tenderness over the rotator cuff or anterior acromial area and positive impingement signs with temporary relief from anesthetic injection. In this case the exam note from 2/2/15 does not demonstrate evidence satisfying the above criteria. Therefore, the request is not medically necessary.

Left carpal tunnel release: Upheld

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

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

Decision rationale: Per the CA MTUS/ACOEM guidelines, Chapter 11 Forearm, Wrist and Hand Complaints page 270, Electrodiagnostic testing is required to eval for carpal tunnel and stratify success in carpal tunnel release. In addition, the guidelines recommend splinting and medications as well as a cortisone injection to help facilitate diagnosis. In this case there is lack of evidence in the records from 2/2/15 of failed bracing or injections in the records. Therefore, the request is not medically necessary.