

<b>Case Number:</b>	CM15-0058614		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	11/15/2013
<b>Decision Date:</b>	05/19/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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: Minnesota, Florida  
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:

The injured worker is a 39 year old male, who sustained an industrial injury on 11/15/2013. He reported slipping and twisting while lifting tubs of silverware, resulting in pain in the low back, neck, and left shoulder. The injured worker was diagnosed as having left shoulder impingement syndrome. Treatment to date has included medications, steroid injection, shoulder sling, chiropractic treatment, electro diagnostic studies, and selective nerve root block. The request is for a left shoulder scope with subacromial decompression and debridement, and post-operative physical therapy. A magnetic resonance imaging of the left shoulder done on 1/25/2014, revealed tendinosis, a small interstitial tear, no rotator cuff tear or labral tear, and findings that would suggest impingement syndrome. On 3/11/2015, he presented with continued left shoulder symptomology that had not responded to a steroid injection given approximately 5 weeks earlier. Physical findings reveal a positive impingement test and tenderness in the shoulder region.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder scope with subacromial decompression and debridement:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 209, 210, 211.

**Decision rationale:** The injured worker was lifting when he slipped and twisted sustaining injuries to his lower back, neck, and left shoulder on 11/15/2013. MRI of the left shoulder dated 1/25/2014 revealed supraspinatus and infraspinatus tendinosis, small interstitial tear in a conjoined portion of the cuff without extension to the cuff surface, no rotator cuff tear or labral tear and MRI findings suggestive of impingement. Nerve conduction studies revealed evidence of bilateral carpal tunnel syndrome, left greater than right. In addition there was entrapment in Guymon's canal and bilateral C5-6 radiculopathy. Progress notes from March 11, 2015 indicate that the shoulder did not respond to a corticosteroid injection although the immediate response to the local anesthetic is not documented. He had difficulty sleeping on the left side and difficulty lifting his left arm to the shoulder level. Examination revealed a positive impingement test. The documentation indicates that the IW failed conservative care including steroid injections but it does not give details about the duration of the conservative care, particularly the number of physical therapy visits and home exercise program and the number of corticosteroid injections. An orthopedic consultation dated 9/22/14 revealed chronic neck pain and bilateral upper extremity pain related to the injury of 11/12/2013. MRI findings of the cervical spine revealed moderate to severe central stenosis at C3-4, severe bilateral foraminal stenosis at C3-4 with moderate foraminal stenosis at C4-5 as well as severe canal stenosis and foraminal stenosis at C5-6. On December 24, 2014 a Neer impingement test was carried out using an injection of corticosteroids and 2 cc of Xylocaine into the subacromial space followed by immediate symptomatic relief. The popping was still present but he could now place his hand behind his back and the acute pain had disappeared. That would indicate that impingement was a factor in the subjective complaints of pain. EMG and nerve conduction studies of 5/6/2014 indicate findings of the moderate to severe carpal tunnel syndrome, left greater than right, bilateral Guymon's canal entrapment of the ulnar nerves and findings of chronic active C5-6 radiculopathy, left greater than right. A C5 radiculopathy causes pain in the lateral shoulder and upper arm and motor weakness of shoulder abduction and elbow flexion. An examination of 11/24/2014 indicates that there was no interest at that time in surgical intervention for the left shoulder. However, the issue with regard to the cervical spine was more complicated. The subjective complaints in the cervical spine were out of proportion to the objective findings and this was of some concern to the examiner. A new MRI scan of the cervical spine was recommended. An examination of 10/27/2014 by Pain Management revealed complaints of neck pain rated 10/10, bilateral radiating pain, numbness tingling or burning and discoloration of his upper extremities into his hands, constant low back pain worse on the left than right which was rated 9/10 and radiating numbness tingling and pain in the lower extremities. The left shoulder was limited to 90 in flexion and abduction. There was normal range of motion of the right shoulder. Based upon a review of these medical records, it is clear that there are 2 different issues involving the cervical spine and the left shoulder. The left shoulder does have evidence of impingement with a positive Neer impingement test using a lidocaine and corticosteroid injection which provided immediate relief and improvement in the range of motion. The impingement diagnosis is also supported by imaging studies. The cervical spine issue pertains to the presence of radiculopathy confirmed by electromyography. The surgical procedure requested at this time is for the impingement syndrome. California MTUS guidelines indicate 3-6 months of

conservative care with injections, physical therapy, and a home exercise program before surgery for impingement syndrome is carried out. Based upon the documentation of the conservative care, it appears that the guideline criteria for subacromial decompression have been met. As such, surgery for impingement syndrome is indicated. In light of the above, the request for subacromial decompression of the left shoulder is supported and the medical necessity of the request has been substantiated

**Post-op physical therapy 3 x a week for 4 weeks for the left shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** California MTUS postsurgical treatment guidelines indicate 24 visits over 14 weeks for rotator cuff syndrome/impingement syndrome. The initial course of therapy is one half of these visits which is 12. Then with documentation of continuing functional improvement, a subsequent course of therapy of the remaining 12 visits may be prescribed. The request as stated is for 12 visits which is appropriate and as such, the medical necessity of the request has been established.