

Case Number:	CM15-0140093		
Date Assigned:	07/29/2015	Date of Injury:	01/24/2014
Decision Date:	10/13/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/20/2015

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, Oregon, Washington
 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 59 year old male, who sustained an industrial injury on 1-24-2014. He reported injury to the right shoulder, neck, and back from heavy lifting and pushing-pulling. Diagnoses include neck pain with cervical spondylosis, chronic low back pain, lumbar spondylosis, right shoulder pain with tendinitis and impingement, and upper extremity paresthesia with right carpal tunnel syndrome. Treatments to date include activity modification, medication therapy, physical therapy, a therapeutic shoulder joint injection, and epidural injections. Currently, he complained of ongoing pain in the right shoulder, neck and back as well as numbness and tingling in the right hand-wrist. On 6-26-15, the physical examination documented pain with range of motion in the cervical spine and right shoulder. There was decreased shoulder range of motion and a positive impingement sign. The right hand demonstrated a positive Phalen's sign. Radiographic imaging of the right shoulder was documented to reveal rotator cuff tendinopathy on 11-12-14. Electrodiagnostic studies were significant for "severe right carpal tunnel syndrome." The plan of care included surgery to the right shoulder and carpal tunnel repair of the right wrist. This appeal requested authorization for a right carpal tunnel release as an outpatient and a right shoulder arthroscopic subacromial decompression as an outpatient. The Utilization Review denied the requests indicating the documentation submitted did not support medical necessity per the ACOEM Guidelines. The Utilization Review further documented "the claimant hurt his neck, back, and shoulder" and "there was not a significant episode that resulted in any pathology that requires surgical procedures."

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right carpal tunnel release: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) surgery for carpal tunnel syndrome.

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 of failed bracing or injections in the records. Therefore, the determination is for non-certification. The Official Disability Guidelines were also referenced for more specific recommendations. According to the Official Disability Guidelines regarding surgery for carpal tunnel syndrome, "Recommended after an accurate diagnosis of moderate or severe CTS. Surgery is not generally initially indicated for mild CTS unless symptoms persist after conservative treatment. Severe CTS requires all of the following: Muscle atrophy, severe weakness of thenar muscles, 2-point discrimination test greater than 6 mm and positive electrodiagnostic testing. Not severe CTS requires all the following: Symptoms of pain, numbness, paresthesia, impaired dexterity requiring two of the following: Abnormal Katz hand diagram scores, nocturnal symptoms, Flick sign (shaking hand); findings by physical exam, requiring two of the following including compression test, Semmes-Weinstein monofilament test, Phalen's sign, Tinel's sign, decreased 2-point discrimination, mild thenar weakness, (thumb adduction); comorbidities of no current pregnancy; initial conservative treatment requiring three of the following: Activity modification greater than or equal to one month, night wrist splint greater than or equal to one month, nonprescription analgesia (i.e. acetaminophen), home exercise training (provided by physician, healthcare provider or therapist) or successful initial outcome from corticosteroid injection trial (optional) and positive electrodiagnostic testing." In this case, there is insufficient evidence of failure of conservative management as stated above. There is insufficient evidence of abnormal hand diagram scores, nocturnal symptoms, decreased two-point discrimination or thenar weakness to warrant surgery. Therefore, the request is not medically necessary.

1 right shoulder arthroscopic subacromial decompression: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, 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 6/26/15. 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 6/26/15 does not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore, the request is not medically necessary.