

<b>Case Number:</b>	CM15-0100511		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	09/21/2012
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	05/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/26/2015

### 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:

The injured worker is a 51-year-old female, with a reported date of injury of 09/21/2012. The diagnoses includes cervical spine disc bulge, status post right shoulder surgery, left shoulder strain, right elbow strain, left elbow strain, right wrist/hand strain, and left wrist/hand strain. Treatments to date have included oral medications. The progress report dated 04/14/2015 indicates that the injured worker complained of pain in her neck, right shoulder/arm, left shoulder/arm, right elbow/forearm, left elbow/forearm, right wrist/hand, and left wrist/hand. It was noted that the injured worker had stomach pain due to the pain medications. The left wrist pain occurred 70 percent of the time. It was noted that the injured worker was not a candidate for surgery, and she should be referred to a pain specialist. The physical examination showed diminished light touch sensation of the right index tip, right dorsal thumb web, and right small tip. The treating physician requested an MRI of the right elbow, an MRI of the right wrist, right wrist/hand De Quervain's surgery, right shoulder arthroscopy, physical therapy for the right upper extremity, physical therapy for the cervical spine, right wrist brace, internal medicine consultation, cortisone injection to the right shoulder, and cortisone injection to the right elbow.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical services: Cortisone injection right elbow: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Cortisone injection right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 211 and 213. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

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

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Internal medicine consult:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, page 127 and Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Preoperative testing.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Right wrist brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, DME.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Right wrist/hand DeQuervain's surgery:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): s 259 and 271. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, and Hand Chapter.

**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, referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature, fail to respond to conservative management, including worksite modifications, have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention, surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits and, especially, expectations are very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan. In this case the exam note from 4/14/15 does not demonstrate any evidence of red flag condition or clear lesion shown to benefit from surgical intervention. Therefore the request is not medically necessary.

**Right shoulder arthroscopy:** 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 Chapter.

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

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 4/14/15. 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 4/14/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

**Associated surgical services: Physical therapy 2 x 6 to the cervical spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter and ACOEM Pain, Suffering and the Restoration of Function Chapter, page 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): s 98-99.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Physical therapy 2 x 6 to the right upper extremity:** 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 Chapter and ACOEM Pain, Suffering, and the Restoration of Function Chapter, page 114.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): s 26-27.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: MRI of the right wrist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, and Hand Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: MRI of the right elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines, Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 35.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

