

<b>Case Number:</b>	CM15-0194448		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	08/28/2007
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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:

This 59 year old woman sustained an industrial injury on 8-28-2007. Evaluations include electromyogram and nerve conductions studies dated 7-21-2015 were normal and shoulder MRI dated 7-16-2015. Diagnoses include right shoulder tendinitis, multilevel small to moderate cervical disc herniations, right wrist extensor tenosynovitis and De Quervain's syndrome, moderate disc herniations in the lumbar and lumbosacral spine, left wrist tenosynovectomy, small lumbar spine disc herniations, left wrist superficial neuropathy, left shoulder bursitis and tendinitis, depression, anxiety, and difficulty sleeping, and chronic cervical spine musculoligamentous sprain-strain. . Treatment has included oral medications. Physician notes dated 8-19-2015 show complaints of neck pain rated 4 out of 10 with radiation to the bilateral upper extremities, right shoulder pain rated 7-8 out of 10, left shoulder pain rated 8 out of 10, bilateral wrist and hand pain rated 7 out of 10 on the left and 4 out of 10 on the right with numbness of the bilateral wrists and hands, and low back pain rated 6 out of 10 with radiation to the left lower extremity. The physical examination shows tenderness to the bilateral biceps tendons, range of motion is noted to be flexion 120 degrees right and 100 degrees left, abduction 35 degrees bilaterally, and external rotation 40 degrees right and 15 degrees left. Hawkin's and Neer's tests were mildly positive on the right and positive on the left. Thoracolumbar spine shows tenderness to the left paraspinal muscles and sacroiliac joint. Range of motion is extension 50 degrees, extension 15 degrees, bilateral lateral bending 20 degrees, right rotation 20 degrees, and left rotation 10 degrees. Recommendations include left shoulder surgical intervention, physical therapy for the lumbar spine, Ultracet, Prilosec, and follow up in six weeks. Utilization Review denied a request for left shoulder acromioplasty, possible Mumford procedure, and possible rotator cuff repair and post-operative physical therapy on 9-5-2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with possible acromioplasty, possible Mumford procedure, and possible rotator cuff repair:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder section, acromioplasty surgery.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209 and 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 8/19/15. 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 8/19/15 does not demonstrate evidence satisfying the above criteria. Therefore the request is not medically necessary.

**Post-operative physical therapy 2 times a week for 3 weeks for the left shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.