

<b>Case Number:</b>	CM14-0145573		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	08/25/2009
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

48 year old female claimant with an industrial injury dated 08/25/10. The patient is status post right carpal tunnel release in 2012, and left carpal tunnel release in 2013. Exam note 06/18/14 states the patient returns with neck pain that is radiating to the shoulders, causing weakness in the arms, and tingling in the hands MRI right shoulder from 7/10/14 demonstrates partial thickness articular supraspinatus tendon tear. Upon physical exam the patient had tenderness along the trapezius muscle bilaterally without spasm, thickening or nodularity. The patient had a 50' flexion, 40' extension, 40' bilateral rotation, and 40' of bilateral bending. Neurogenic compression tests are positive bilaterally and vascular compression tests are negative. The patient had an absent Hoffman's test. There was no evidence of swelling, atrophy, asymmetry, or ecchymosis present. The patient had 4+/5 motor strength bilaterally, and the Impingement tests I and II are positive. Sensation is decreased in all fingers, with a two point discrimination of 7mm in all digits. X-rays of the cervical spine demonstrate a loss of cervical lordosis, there is evidence of spurring on the undersurface of the acromion of the shoulders. Also there was mild soft tissue swelling of the right hand and wrist. X-rays of the lumbar spine demonstrate degenerative disc disease at the L5-S1 level. Diagnosis includes a disc herniation at C5-6 of the cervical spine, rotator cuff tears on the bilateral shoulders, recurrent bilateral carpal tunnel syndrome, and a disc herniation at the L5-S1 level of the lumbar spine. Treatment includes a continuation of medication, physical therapy, a cold therapy unit, and a shoulder sling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Pump; purchase:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Shoulder Sling; purchase:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cold therapy unit; purchase:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postop Physical Therapy; twelve (12) sessions (3x4):** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preop clearance prior to surgery to include H&P, CBC, CMP, PT/PTT, UA, EKG:** 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

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

**Dx/opa right shoulder PASTA repair and acromioplasty:** Upheld

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

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

**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 6/18/14. 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 6/18/14 does not demonstrate evidence satisfying the above criteria. Therefore the determination is not medically necessary.