

<b>Case Number:</b>	CM14-0213330		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	02/14/2007
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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, Sports Medicine

### 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 49-year-old male who reported an injury on 02/14/2007. The mechanism of injury was due to repetitiveness of his customary job duties. The injured worker has diagnoses of carpal tunnel syndrome, bilateral wrists; de Quervain's, bilateral wrists; bilateral shoulder strain; degenerative disc disease of the cervical spine; cervical radiculopathy; and lumbosacral strain. Past medical treatments consist of therapy, injections, and medication therapy. Medications include Naprosyn, hydrocodone, and omeprazole. On 07/11/2014, the injured worker underwent an MRI of the left shoulder, which revealed low grade partial thickness articular surface tear of the anterior leading edge of the supraspinatus at the level of the footprint superimposed upon a background of tendinopathy. On 07/11/2014, the injured worker underwent an MRI of the right shoulder, which revealed high grade partial thickness bursal surface tear of the anterior leading edge of the supraspinatus at the level of the footprint with some possible foci of full thickness extension. There was no significant rotator cuff or deltoid muscle atrophy. On 11/12/2014, the injured worker complained of bilateral shoulder pain that starts after lifting and doing any type of lifting or carrying. Physical examination of the shoulders revealed that there was no winging or drooping. There was no obvious dislocations or subluxations noted. No deformities were noted in the clavicle, scapula, or humerus. There was no evidence of any surgical scars. The injured worker showed no tenderness over the sternum, clavicle, humerus, scapula acromion, coracoid process, or the cervical spine. There was no tenderness noted over the rotator cuff muscles, pectoralis major or minor, deltoid, long and short head of biceps or triceps. The anterior aspect of the acromion was not tender. The subdeltoid

bursa was mildly tender, and there was a sign of inflammation. There was no probable defect, crepitus, or tenderness at the acromioclavicular joint. Range of motion of the right shoulder revealed an abduction of 0 to 140 degrees, adduction of 0 to 30 degrees, flexion at 0 to 150 degrees, and extension to 0 to 40 degrees, internal rotation to 0 to 60 degrees, and external rotation to 0 to 80 degrees. Examination of the left shoulder revealed abduction of 0 to 150 degrees, adduction of 0 to 30 degrees, flexion of 0 to 150 degrees, extension of 0 to 40 degrees, internal rotation of 0 to 80 degrees, and external rotation of 0 to 80 degrees. Neurologically, there was no evidence of injury to the suprascapular, axillary, or long thoracic nerves. Testing for instability included the load and shift test, modified load and shift test, apprehension test, sulcus sign test, and posterior apprehension tests were normal. Impingement evaluation, including Neer's impingement sign, Hawkins impingement sign, Jobe's test, and reverse Jobe's test, were positive. Medical treatment plan is for the injured worker to undergo Mumford resection. Rationale and Request for Authorization form were not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Mumford Resection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mumford Procedure

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Partial claviclectomy (Mumford procedure).

**Decision rationale:** The request for Mumford resection is not medically necessary. The ODG states criteria for Mumford procedure is "at least 6 weeks of care directed toward symptom relief prior to surgery, pain at AC joint; aggravation of pain with shoulder motion or carrying weight." There should also be evidence of tenderness over the AC joint (post symptomatic patients with partial AC joint separation have a position bone scan). There should also be on imaging findings conventional films that show either posttraumatic changes of AC joint, severe DJD of AC joint, or complete or incomplete separation of AC joint. The submitted documentation indicated on MRI that the injured worker's AC joints were intact. It was also noted on physical examination that there were no obvious dislocations or subluxations. No deformities were noted in the clavicle, scapula, or humerus. The examinee had normal symmetry and movement of the shoulders with walking. There was no tenderness to palpation over the sternum, clavicle, humerus, scapula acromion, coracoid process, or cervical spine. The anterior aspect of the acromion was nontender. There was no palpable defect, crepitus, or tenderness at the acromioclavicular joint. Additionally, the request as submitted did not specify what shoulder the provider was requesting the Mumford resection for. Given the evidence based guidelines and the submitted documentation, the injured worker is not within guideline criteria. As such, the request is not medically necessary.