

<b>Case Number:</b>	CM15-0116959		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	02/02/2007
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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, Indiana, Oregon  
 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 42 year old female, who sustained an industrial injury on 2/2/07. The injured worker has complaints of low back pain; left shoulder pain; bilateral hand numbness and bilateral hand pain. The diagnoses have included lumbar radiculopathy; impingement syndrome; lumbar herniated nucleus pulposus (HNP) without myelopathy and erythema nodosum. Treatment to date has included psychology therapy; X-rays; lumbar spine magnetic resonance imaging (MRI) of the lumbar spine on 3/25/15 showed mild progression of degenerative disc and facet disease at L3-4 and L4-5 but no nerve root compression; magnetic resonance imaging (MRI) of the left shoulder on 12/14/13 suggesting the clinical syndrome of impingement, including a supraspinatus and infraspinatus tendinosis, anterolateral angulated type 111 acromion with loss of the subdeltoid fat plan, hertrophic acromioclavicular (AC) joint the small bowel spur; cane for ambulation assistance; oxycontin and flexeril. The request was for left shoulder arthroscopic acromioplasty distalclaviclectomy; post-operative physical therapy for the left shoulder; purchase of pain pump; 21 day rental of continuous passive motion unit and purchase of cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic acromioplasty distalclaviclectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Online Version (updated 05/04/2015).

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

**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. 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 notes do not demonstrate evidence satisfying the above criteria notably the relief with anesthetic injection. Therefore the request does not adhere to guideline recommendations and is not medically necessary.

**Post operative physical therapy for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

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

**Associated surgical service: Purchase of pain pump:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines , Second Edition 2004 Chapter 6, Pain, Suffering and the Restoration of Function; Official Disability Guidelines (ODG).

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

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

**Associated surgical service: 21 day rental of continuous passive motion (CPM) unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Second Edition

2004, Chapter 6, Pain, Suffering, and the Restoration of Function; Official Disability Guidelines (ODG).

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

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

**Associated surgical service: Purchase of cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ACOEM Practice Guidelines , Second Edition, Chapter 6, Pain , Suffering, and the Restoration of Function; Official Disability Guidelines (ODG).

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

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