

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/19/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/7/2013  
Date of Injury: 2/28/2013  
IMR Application Received: 8/16/2013  
MAXIMUS Case Number: CM13-0011064

Dear [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

/jr

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

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

The patient reported an injury on 02/26/2013. The patient is noted to have been initially diagnosed with bilateral carpal tunnel syndrome per clinical note signed by Dr. [REDACTED]. She is reported to have previously undergone an anterior cervical discectomy and fusion at C5-6 on 07/23/2012, and reported since that surgery she had pain in her neck, as well as pain that radiated into her upper arms, and stated the pain in her neck, as well as the pain radiating up into her upper arms and shoulders seemed to have resolved. She did not note much change in her hand symptoms; the left was worse than the right. She had numbness and tingling in a median nerve distribution. She also reported after the cervical spine surgery, she developed pain and stiffness in her left shoulder and she had been doing physical therapy for that. On physical examination on that date, she was reported to have findings consistent with adhesive capsulitis with active and passive forward flexion to 90 degrees, external rotation at 45 degrees, and internal rotation to the PSIS. The patient is reported to have undergone electrodiagnostic studies, which were positive for carpal tunnel syndrome and she was reported to have had 8 cortisone injections to her bilateral wrists without improvement. An MRI of the left shoulder performed on 03/07/2013 noted a small full-thickness tear near the insertion of the supraspinatus tendon anteriorly. A clinical note dated 07/26/2013 noted the patient had undergone a right carpal tunnel release on 05/16/2013, which she reported was doing very well. She noted the numbness and tingling had resolved in her right fingers and there was only mild discomfort in her palm. The patient is reported on examination of the left shoulder to have some anterior diffuse tenderness, no signs of adhesive capsulitis. She had pain when she elevated her arm to 90 degrees and also pain on abduction. She had only mild discomfort with external rotation, no weakness on external rotation, internal rotation was painful, but the subscapularis liftoff test was negative. She had a positive Hawkins impingement sign.

## IMR DECISION(S) AND RATIONALE(S)

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

### **1. Left shoulder arthroscopy, subacromial decompression and rotator cuff repair is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Occupational Medicine Practice Guidelines, which is part of the MTUS and the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9), pages 209-211, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The employee reported an injury on 02/28/2012 and is noted to have initially been diagnosed with cervical pain with radiation of pain to the bilateral upper extremities. The employee is reported to have undergone an ACDF at C5-6 on 07/23/2012 and it is reported the employee's radiation of pain to upper extremities seems to have resolved; however, there was no change in hand symptoms, the left being worse than her right. The employee also reported after cervical surgery the employee developed pain and stiffness in the left shoulder and a clinical note dated 03/05/2013 noted the employee had been treating with physical therapy for that. The employee is reported to have undergone electrodiagnostic studies that confirm bilateral carpal tunnel syndrome and to have findings of a small full-thickness tear near the insertion of the supraspinatus tendon anteriorly on an MRI of the left shoulder. The employee is noted on physical examination to have diffuse anterior tenderness, pain when elevating her arms 90 degrees and above, pain with abduction, only mild discomfort with external rotation, and no weakness, internal rotation was painful, but without weakness, and the employee had a positive Hawkins test. The California MTUS Guidelines recommend a subacromial decompression after conservative care, including cortisone injections have been carried out for at least 3 to 6 months before considering surgery and recommend a rotator cuff tear, which presents primarily as impingement after failing conservative therapy for at least 3 months. The employee is reported to have attended physical therapy for treatment of right shoulder, but there is no indication of the number of visits or length of time that physical therapy was performed and there is no documentation that the employee has undergone a subacromial injection to the left shoulder with temporary relief of pain. **The request for a left shoulder arthroscopy, subacromial decompression and rotator cuff repair is not medically necessary and appropriate.**

### **2. Pre-operative Electrocardiogram (EKG) is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The employee reported to have developed left shoulder pain following a cervical surgery. The employee is noted to have undergone an MRI that shows a small full-thickness tear and is reported on physical exam to have painful arc of motion and a positive Hawkins impingement sign. The employee was planned for a left shoulder subacromial decompression and rotator cuff repair. The California MTUS Guidelines do not address the request. The Official Disability Guidelines state preoperative electrocardiograms are not recommended for endoscopic or ambulatory procedures. As the employee is undergoing a left shoulder arthroscopic subacromial decompression and rotator cuff repair, which is an ambulatory procedure, the request for a preoperative electrocardiogram does not meet guideline recommendations. In addition, as the requested surgery has not been certified, the need for preoperative testing is not established. **The request for a pre-operative Electrocardiogram (EKG) is not medically necessary and appropriate.**

### **3. Chest X-ray is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The employee reported an injury on 02/28/2012 and is noted to have undergone a cervical fusion in 07/2013. The employee developed left shoulder pain immediately following the surgery and is reported to have undergone some physical therapy to the left shoulder. The medical records provided for review indicate the employee underwent an MRI which showed a small full-thickness tear of the supraspinatus tendon at its insertion site. The employee is noted on physical exam to have a painful arc of motion, tenderness to palpation over the anterior shoulder, and positive impingement sign. The employee was planned for a left shoulder subacromial decompression and rotator cuff repair. A request was submitted for a preoperative chest x-ray. The California MTUS Guidelines do not address the request. The Official Disability Guidelines state a chest x-ray is reasonable for patients at risk for postoperative pulmonary complications if the results would change preoperative management. As there is no indication that the employee is at risk for pulmonary complications, and the requested shoulder surgery has not been certified, the need for preoperative chest x-ray is not established. **The request for a pre-operative chest X-ray is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]  
[REDACTED]  
[REDACTED]