

Case Number:	CM14-0006811		
Date Assigned:	02/07/2014	Date of Injury:	01/28/2013
Decision Date:	06/23/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/17/2014

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, has a subspecialty in Sports Medicine, and is licensed to practice in Pennsylvania. 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. 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:

The claimant is a 43-year-old, female who injured her shoulder and neck on 01/28/13. The report of a right shoulder MRI dated 02/26/13 identified a signal change of the rotator cuff consistent with tendinosis, but no indication of full thickness rotator cuff findings. There was no other imaging to the shoulder noted. The follow up report of 11/21/13 noted continued complaints of discomfort in the shoulder with tenderness to palpation on examination, pain at the acromioclavicular joint, bicipital tenderness on palpation, positive impingement, and 4/5 rotator cuff strength. Examination of the neck showed restricted motion at endpoints, increased pain with palpation, negative Spurling's testing, and diminished sensation in a C6 dermatomal distribution bilaterally. The report of a cervical MRI of 03/18/13 showed a paracentral disc protrusion at C6-7 with neural foraminal narrowing. Conservative care was documented to have included home exercises, medication management, but no indication of a course of physical therapy or injections for the cervical spine or shoulder. Arthroscopic intervention was recommended to the shoulder and referral to a "spine specialist" to discuss further cervical spine treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, 9 (SHOULDER COMPLAINTS) (2004), 210

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), 9, 211

Decision rationale: The California ACOEM Guidelines do not support the request for right shoulder arthroscopy. The medical records indicate that the employee is diagnosed with impingement but there is no documentation of conservative care to have included physical therapy or injections. The ACOEM Guidelines recommend six months of conservative measures including injection therapy prior to proceeding with operative procedure for impingement. Therefore, based on the ACOEM recommendation, the specific surgical request would not be supported.

UNKNOWN POST-OPERATIVE PHYSICAL THERAPY SESSIONS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST-SURGICAL TREATMENT GUIDELINES, ROTATOR CUFF SYNDROME/IMPINGEMENT SYNDROME (ICD9 726.1; 726.12);

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

CONSULTATION WITH SPINAL SPECIALIST TO DISCUSS CERVICAL SPINE SURGERY: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, 8 (NECK AND UPPER BACK COMPLAINTS) (2004), 166, 179

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), 7, 127

Decision rationale: The California ACOEM Guidelines would support the role of consultation with a spinal surgeon. This individual is documented to have a C6-7 disc protrusion with concordant findings on examination and has failed conservative care. A consultation for further options in regard to cervical treatment would be supported.

UNKNOWN DURABLE MEDICAL EQUIPMENT (DME): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)--TREATMENT IN WORKERS' COMP (TWC): KNEE PROCEDURE--DURABLE MEDICAL EQUIPMENT (DME).

Decision rationale: The California MTUS and ACOEM Guidelines do not address durable medical equipment. The Official Disability Guidelines would not support "unknown durable medical equipment." This request is vague with no indication of the specific durable medical equipment or device in question. It should be noted that the surgical request for the employee's shoulder in this case has not been supported. This clinical request would not be indicated.

PRE-OPERATIVE MEDICAL EVALUATION/CLEARANCE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), 7, 127

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