

Case Number:	CM15-0167886		
Date Assigned:	09/08/2015	Date of Injury:	12/09/2009
Decision Date:	10/27/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/26/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 52 year old female, who sustained an industrial injury on 12-9-2009. The medical records submitted for this review did not include the details regarding the initial injury or prior treatments to date. The diagnoses included rotator cuff syndrome and osteoarthritis. The injured worker has a history of left subacromial decompression, distal clavicular resection, and rotator cuff repair with ongoing left shoulder pain. PR-2 note 07/02/2015 describes chronic low back pain, with positive bilateral straight leg raise, and diagnosis of lumbar radiculopathy. The documentation submitted did not demonstrate that the injured worker has significant lower extremity weakness, but some records show that her gait is antalgic. Currently, she complains of worsening pain in the left shoulder and lumbar spine. On 7-15-15, the physical examination documented left shoulder tenderness with positive cross arm test and a positive Hawkins- Kennedy test. The plan of care included a request to authorize a left shoulder injection under ultrasound guidance, a mobile commode, and a small shower chair per a 7-15-15 order.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder SA injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Criteria for steroid Injections.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

Decision rationale: According to the California ACOEM, shoulder injections with cortisone can be considered to treat subacute and/or chronic conditions such as impingement syndrome, or rotator cuff tears. If after 3-4 weeks of conservative care to include medications and/or physical therapy, the symptoms persist, the ACOEM recommend consideration of injections at this time. There is no mention of recent failure of conservative treatment for the injured workers impingement syndrome, and as such, this request is not medically necessary at this time.

Ultrasound guidance QTY: 1.00: 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.

Mobile commode QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapters, Durable Medical Equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, DME.

Decision rationale: The Official Disability Guidelines state that certain DME toilet items (commodes) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. Within the submitted documentation, there is no mention that the injured worker is confined to a single room. There is no mention of significant lower extremity weakness, despite diagnosis of lumbar radiculopathy and chronic back pain. Medically necessity has not been substantiated.

Small shower chair QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapters, Durable Medical Equipment (DME).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Leg Chapter, DME.

Decision rationale: The Official Disability Guidelines state that certain DME toilet items (commodes, shower chairs) are medically necessary if the patient is room-confined or when prescribed as part of a medical treatment plan for injury or conditions that result in physical limitations. Within the submitted documentation, there is no mention that the injured worker is confined to a single room. There is no mention of significant lower extremity weakness, despite diagnosis of lumbar radiculopathy and chronic back pain. Medically necessity has not been substantiated.