

Case Number:	CM15-0002128		
Date Assigned:	01/13/2015	Date of Injury:	06/14/2014
Decision Date:	03/13/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/06/2015

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

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 51-year-old female who reported an injury on 06/14/2014 due to cumulative trauma. On clinical note dated 11/25/2014, noted the injured worker had complaints of constant pain in the bilateral shoulders with associated numbness and tingling. Examination of the bilateral shoulders noted nonspecific tenderness and tenderness to palpation over the acromioclavicular joint, anterior labrum, supraspinatus, infraspinatus, acromion and upper trapezius on the right. Moderate tenderness at the acromioclavicular joint, anterior labrum, supraspinatus, infraspinatus, acromion and upper trapezius on the left. Positive bilateral impingement maneuver, Codman drop arm test and Apley's scratch test. There was decreased range of motion to the bilateral shoulder right more than left. Diagnoses were bilateral shoulder sprain/strain. Provider treatment plan included bilateral shoulder arthroscopy, right side first and left side 6 weeks later, DME cold therapy unit, and associated postoperative physical therapy. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral shoulder arthroscopy, Right side first then Left side 6 weeks later: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214, table 9-6.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 209-210.

Decision rationale: The request for Bilateral shoulder arthroscopy, Right side first then Left side 6 weeks later is not medically necessary. The California MTUS Guidelines state referral for surgical consultation would be indicated for injured worker with red flag conditions and activity limitation for more than 4 months, plus existence of a surgical lesion. There should be evidence of the injured worker's failure to respond to conservative treatment to include physical therapy, exercise programs, and medications. The Official Disability Guidelines further state that a diagnostic arthroscopy is recommended, and limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. The documentation submitted for review lacked evidence of the injured worker's initial unresponsiveness to conservative treatment to include physical therapy, exercise, injections, and medications. Additionally, there were no imaging studies submitted for review. As such, medical necessity has not been established.

ASSOCIATED SURGICAL SERVICES: DME (Durable Medical Equipment) cold therapy unit: 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.

ASSOCIATED SURGICAL SERVICES: Post-op physical therapy 1x2 each side then 3x4 each side: 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.