

Case Number:	CM15-0178401		
Date Assigned:	09/18/2015	Date of Injury:	02/14/2013
Decision Date:	11/09/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/10/2015

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 46 year old female who sustained an industrial injury on 02-14-2013. Diagnoses include bilateral shoulder strain-rule out rotator cuff tear and impingement syndrome, cervical spine sprain-rule out radiculopathy and disc pathology, upper back strain, sleep disturbances and mild depression related to work, bilateral thumb DeQuervain's syndrome, and bilateral wrist carpal tunnel syndrome with weakness. The most recent physician progress note dated 03-31-2015 documents the injured worker has complaints of left shoulder pain radiating to her neck and upper back into the shoulder blades, and the pain is worse with motion of her neck and reaching. She has low back pain on the right that radiates up into the thoracic spine and it increased with activity. She also has complaints of bilateral thumb, wrist and hand pain. She has tenderness to palpation over the bicipital groove and osseous structures. Shoulders ranges of motion are limited in all direction by 20 percent with pain during Speed's test. In addition she has palpable paraspinal spasms and tenderness to the spinous, paravertebral musculature, anterior scalene muscles and trapezius muscles. Treatment to date has included diagnostic studies. A Magnetic Resonance Imaging of the left shoulder done on 08-25-2015 showed swelling of the subacromial bursa compatible with bursitis and tendinitis. On 08-18-2015 the Utilization Review denied the requested treatments of associated surgical service: assistant surgeon, associated surgical service: Cold therapy unit, pre op EKG, pre-op labs, and right shoulder arthroscopy, decompression, and possible repair at Coastline Surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, decompression, and possible repair at Coastline Surgery:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC; ODG Treatment and API Plus, 2009.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, pages 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 records 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.

Associated surgical service: Assistant surgeon: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op Labs: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op EKG: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: 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: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.