

Case Number:	CM14-0145952		
Date Assigned:	09/12/2014	Date of Injury:	07/08/2009
Decision Date:	10/22/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Family Practice, 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 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/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 injured worker is a 56 year old female who reported an injury to both shoulders. No information was submitted regarding the initial injury. The utilization review dated 08/12/14 resulted in denials for a consultation as well as chiropractic treatments for the cervical spine as insufficient information had been submitted confirming the medical need for the request. The clinical note dated 08/28/14 indicates the injured worker complaining of 9/10 pain at both shoulders. Lifting objects and raising the arms exacerbated the injured worker's pain. There is an indication the injured worker had undergone an MRI of the right shoulder which revealed a partial thickness tear at the rotator cuff. A SLAP tear was also identified at the left shoulder as revealed on the MRI. The injured worker was able to demonstrate 150 degrees of right shoulder flexion, 160 degrees of left shoulder flexion, 159 degrees of abduction at the right shoulder, and 165 degrees at the left. Electrodiagnostic studies completed on 08/08/14 revealed no evidence of cervical radiculopathy. Findings were consistent with a borderline bilateral carpal tunnel syndrome. The clinical note dated 05/16/14 indicates the injured worker having tenderness upon palpation throughout the cervical region. The injured worker rated the cervical pain as 7/10. The injured worker was able to demonstrate 49 degrees of cervical flexion, 50 degrees of extension, 37 degrees of left lateral bending, 39 degrees of right lateral bending, 75 degrees of left rotation, and 65 degrees of right rotation. No sensory deficits were identified. Minimal strength deficits were identified at the left deltoid and biceps which were rated as 5-/5. There are indications the injured worker has undergone 3 months of conservative treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Upper GI series: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation .) Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins. 2.) Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby Elsevier.

Decision rationale: The request for an upper GI series is certified. The documentation indicates the injured worker complaining of cervical and bilateral shoulder pain. Additionally, the clinical notes indicate the patient having ongoing complaints of GI upset. Given these findings, an Upper GI series is indicated in order to provide the injured worker with a pathway for treatment. Therefore, this request is medically necessary.

Abdominal ultrasound: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC) Index (updated 03/19/2013)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Fischbach FT, Dunning MB III, eds. (2009). Manual of Laboratory and Diagnostic Tests, 8th ed. Philadelphia: Lippincott Williams and Wilkins. 2.) Pagana KD, Pagana TJ (2010). Mosby's Manual of Diagnostic and Laboratory Tests, 4th ed. St. Louis: Mosby Elsevier.

Decision rationale: The request for an abdominal ultrasound is certified. The clinical notes indicate the patient having complaints of GI upset. Given these findings, an abdominal ultrasound is indicated in order to identify the cause of the complaints. Therefore, this request is reasonable.