

Case Number:	CM14-0111315		
Date Assigned:	09/19/2014	Date of Injury:	06/05/2013
Decision Date:	10/17/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/15/2014

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 Orthopedic Surgery and is licensed to practice in Minnesota. 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 53 year old obese male involved in a motor vehicle accident on 06/05/2013. He was initially treated for low back pain and radicular pain in the lower extremities. An MRI scan of the lumbosacral spine was performed on 07/01/2013 and revealed mild degenerative disc disease at L4-5 and L5-S1. His back pain persisted and he underwent a lumbar spinal fusion on 12/09/2013. He also sustained trauma to the cervical spine and complained of left sided neck pain and radicular pain and numbness in the left hand . Xrays of the cervical spine revealed moderate foraminal narrowing at C5-6 on the left. An MRI scan of the cervical spine was performed on 04/16/2014 and revealed a herniated disc with severe neuroforaminal narrowing at C5-6 on the left. The assessment on 04/22/2014 was cervical radiculopathy and cubital tunnel syndrome. Physical therapy was prescribed three times a week for six weeks. He was also evaluated for left shoulder pain and found to have impingement. MRI scan of the left shoulder revealed no evidence of rotator cuff tear or tendinosis. However, there was a type II acromion, severe acromioclavicular arthritis and complete attrition rupture with shredding of the long head of biceps at the supraglenoid tubercle. Shoulder examination on 4/21/2014 revealed no tenderness over the AC joint or bicipital groove. Shoulder elevation was 160 degrees and abduction 120 degrees. External rotation was 40 degrees and internal rotation was to T12. There was evidence of impingement and weakness of the supraspinatus reported. He was treated with physical therapy. The available documentation does not indicate an accurate assessment of the pain source by performing the Neer Impingement test. Corticosteroid injections into the subacromial space or the acromioclavicular joint are not documented. EMG and nerve conduction studies have also not been performed to make a definitive diagnosis of cervical radiculopathy resulting from the herniation at C5-6. The disputed issues include scope

acromioplasty, rotator cuff repair left shoulder, post-operative physical therapy, left shoulder 3 times a week for 6 weeks, medical clearance, and Norco 10/325 mg #40.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scope Acromioplasty Rotator Cuff Repair, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213..

Decision rationale: The available records document MRI evidence of a herniated disc at C5-6 on the left associated with severe neuroforaminal narrowing and radicular symptoms including pain, paresthesias and numbness in the left upper extremity related to neck motion. Because C5 or C6 radiculopathy can present as shoulder pain or dysfunction, an accurate assessment of the known radiculopathy with electromyography and nerve conduction studies will be necessary. A detailed neurologic examination of the cervical spine and upper extremities is not documented. The shoulder MRI does not document the presence of rotator cuff tendinitis, or an impingement tear to support the clinical diagnosis of impingement syndrome. The Neer impingement test can be useful to confirm the origin of pain. If the diagnosis of impingement syndrome is confirmed, corticosteroid injections into the subacromial bursa should be tried with other conservative treatment for 3-6 months before contemplating surgery. The ruptured biceps tendon is usually due to degenerative changes in the tendon. This is not associated with functional disability and should be managed conservatively. The MRI scan does not show the presence of a full thickness rotator cuff tear. In the absence of diagnostic lidocaine injections to distinguish pain sources in the shoulder area and two or three subacromial injections of local anesthetic and cortisone preparations over an extended period as part of an exercise rehabilitation program, the guidelines do not recommend surgery. Therefore, the request for surgical procedure of scope acromioplasty and rotator cuff repair, left shoulder is not medically necessary.

Post Operative Physical Therapy, 3 Times a Week for 6 Weeks, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213..

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

Medical Clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=38289> Pre operative evaluation

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213..

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

Norco 10/325mg #40: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213.

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

Ambien 10 MG #10: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Zolpidem (Ambien)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213..

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

Keflex 500 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Infectious Diseases updated 02/21/2014 Cephalexin (Keflex)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 204, 210, 211, and 213..

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