

Case Number:	CM14-0154069		
Date Assigned:	09/23/2014	Date of Injury:	11/13/2013
Decision Date:	10/24/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/22/2014

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 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:

This 20-year-old female packer sustained an industrial injury on 11/13/13. Injury occurred when she was pulling bins of celery weighing up to 1000 pounds from one roller to another and felt a sudden sharp pain in the right neck radiating to the shoulder and upper extremity. Initial conservative treatment included 6 visits of physical therapy, 2 sessions of chiropractic, and 8 sessions of acupuncture with no sustained benefit. The 6/16/14 bilateral upper extremity EMG/NCV impression documented a normal study with no electrodiagnostic evidence of focal nerve entrapment, cervical radiculopathy, or generalized peripheral neuropathy. The 7/2/14 right shoulder MRI impression documented axillary muscle edema and strain partially evaluated at the periphery of this MRI. There was mild to moderate rotator cuff tendinosis with and subacromial/subdeltoid bursitis. There was a lateral down sloping acromion and mild to moderate acromioclavicular joint degenerative change. There was no definite diffuse labral tear appreciated. The 7/8/14 treating physician report cited moderate to severe right shoulder and neck pain. She reported her shoulder felt swollen and muscle cramps made her arm difficulty to move. Pain increased with any movement or use of the arm and was worse at night. Functional loss was documented in activities of daily living. Right shoulder range of motion was painfree with flexion 160, extension 60, abduction 180, external rotation 90, and internal rotation 70 degrees. There was minimal tenderness over the acromioclavicular joint and trapezius. Shoulder orthopedic testing was negative. There were no signs of instability. Strength, sensation and deep tendon reflexes were normal over the upper extremity. The diagnosis was right shoulder bursitis, impingement and rotator cuff tendinosis. The treatment plan recommended continued home exercise program, additional acupuncture, activity modification, work restrictions, medication, and ice. A corticosteroid injection would be considered at the next visit. The 8/21/14 initial orthopedic report cited continued right sided neck and shoulder pain. Physical exam documented

pain and muscle spasms from C3 to C7 extending to the posterior aspect of the right shoulder. Cervical range of motion was markedly limited. Palpation of the right shoulder demonstrated pain mostly at the junction of the rotator cuff and acromion. Shoulder range of motion was limited to flexion 80, abduction 85, internal rotation 60, and external rotation 40 degrees. Weakness was noted with resisted abduction and external rotation. Impingement test was positive. Grip strength was decreased on the right. There was right upper extremity weakness consistent with C5/6 and C6/7. Upper extremity strength was otherwise 5/5, sensation was normal, and deep tendon reflexes were responsive. The diagnosis was right shoulder bony impingement syndrome and multiple cervical disc derangement with probable compression neuropathy and cervical radiculopathy. The treatment plan recommended arthroscopic subacromial decompression with associated pre-operative and post-operative requests, cervical spine MRI, and additional EMG/NCV studies. The patient remained off work. The 9/5/14 utilization review denied the request for bilateral upper extremity EMG as it was not related to the right shoulder injury. The request for shoulder surgery was denied pending evaluation of cervical spine pathology contributing to shoulder symptoms and absent guideline-recommended conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 182.

Decision rationale: The California MTUS guidelines do not recommend EMG for diagnosis of nerve root involvement if findings or history, physical exam, and imaging study are consistent. EMG is recommended to clarify nerve root dysfunction in cases of suspected disc herniation pre-operatively or before epidural injection. Guideline criteria have been met. This patient underwent electrodiagnostic studies on 6/16/14 that were found to be normal. Cervical MRI has been requested and is pending. There is no evidence of progressive neurologic deficit to support the medical necessity of repeat electrical studies. Therefore, this request is not medically necessary.

Right shoulder arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Surgery for Impingement Syndrome

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including corticosteroid injection, and failure has not been submitted. There is no evidence of a diagnostic injection test for impingement. Therefore, this request is not medically necessary.

Preop internal medicine consult for UA, blood work, xray and EKG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38; ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Post operative physical therapy, 2-3 times a week for 4-6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): page(s) 27.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.

Post-op pain medicine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Page(s): 76-80.

Decision rationale: As the surgical request is not supported, this request is not medically necessary.