

Case Number:	CM14-0168648		
Date Assigned:	10/16/2014	Date of Injury:	08/08/2006
Decision Date:	12/10/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/13/2014

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 Internal Medicine, 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 patient is an injured worker with a history of left shoulder rotator cuff surgery, cervical pain, cervical facet syndrome, post cervical laminectomy syndrome. Date of injury was 08-08-2006. Psychiatric evaluation report dated March 18, 2014 documented that on 8/8/06; the patient was driving a vehicle and was making a right turn. Trying to avoid hitting a nearby car, he overturned, and felt popping sensations in his left shoulder and neck. MRI magnetic resonance imaging was performed which demonstrated a rotator cuff tear. Surgery was performed 4/2/07. X-ray of the cervical spine dated 4/5/13 demonstrated postoperative changes and degenerative changes. The progress report dated 9/15/14 documented subjective complaints of neck pain. He stated that medications are working well. Medications included Percocet 10-325 mg four times a day as needed, Fenofibrate, Orphenadrine, Hydrochlorothiazide, and Lisinopril. [REDACTED] [REDACTED] dated 7/21/14 was appropriate. Objective findings were documented. He appears to be well groomed. The patient appears to be well nourished and well developed. He has good communication ability. Patient ambulates without a device. Gait of the patient is normal. Inspection of the cervical spine reveals surgical scar. Range of motion is restricted with flexion limited to 8 degrees, extension limited to 10 degrees, right lateral bending limited to 15 degrees, left lateral bending limited to 15 degrees, lateral rotation to the left limited to 50 degrees and lateral rotation to the right limited to 45 degrees. On examination of paravertebral muscles, tenderness and tight muscle band is noted on both the sides. Tenderness is noted at the paracervical muscles and trapezius. Spurling's maneuver produces no pain in the neck musculature or radicular symptoms in the arm. Inspection of the right shoulder joint reveals no swelling, deformity, joint asymmetry or atrophy. No limitation is noted flexion, extension, adduction, abduction, active elevation, passive elevation, internal rotation or external rotation. Hawkins test is positive. Speeds test is positive.

