

Case Number:	CM14-0174642		
Date Assigned:	11/03/2014	Date of Injury:	05/17/2014
Decision Date:	12/17/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/21/2014

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:

59-year-old male claimant with an industrial injury dated 05/17/14. MRI of the bilateral shoulders dated 06/22/14 reveals full-thickness tear of the left supraspinatus tendon and an intrasubstance partial tear and degeneration of the right supraspinatus tendon. MRI of the lumbar spine dated 06/25/14 reveals multi-level degenerative changes and mild to severe stenosis at L2-3, L3-4, and L4-5 with evidence of acute disc disease. Exam note 09/23/14 states the patient returns with neck, shoulders, low back, and right leg/knee pain. Upon physical exam there was tenderness surrounding the cervical spine. The patient demonstrated a painful flexion and extension. There was also tenderness over the lateral and anterior aspects of the shoulders with the left worse than the right. The patient demonstrated weakness with external rotation of both shoulders. The patient has a noted positive Neer's, Hawkins, and Jobe's test. The patient had hamstring tightness and a bilateral straight leg raise. The patient demonstrated decreased sensations to light touch over the left foot with a positive left foot drop. Treatment includes a Left Shoulder Arthroscopic Rotator Cuff Repair, Physical Therapy, and a Steroid Injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Surgical consult for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Per the CA MTUS ACOEM 2004, Chapter 7, page 127 states the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. In this case the records from 9/23/14 not demonstrate any objective evidence or failure of conservative care to warrant a specialist referral. Therefore the determination is not medically necessary.

Left shoulder arthroscopic rotator cuff repair: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair

Decision rationale: According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 9/23/14 do not demonstrate 4 months of failure of activity modification. The physical exam from 9/23/14 does not demonstrate a painful arc of motion, night pain or relief from anesthetic injection. Therefore the determination is not medically necessary.

Post-Op physical therapy for the left shoulder, #12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Cold therapy unit for 10 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Pre-Op medical clearance with internist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, pgs. 92-93

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

Neurological consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Per the CA MTUS ACOEM 2004, Chapter 7, page 127 states the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. In this case the exam note from 9/23/14 not demonstrates any objective evidence or failure of conservative care to warrant a neurologic consultation. Therefore the determination is not medically necessary.

EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel section

Decision rationale: CA MTUS/ACOEM is silent on the issue of EMG/NCV testing. According to the ODG, Carpal tunnel section, "Recommended in patients with clinical signs of CTS who may be candidates for surgery? Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS)." In this case there is no evidence of neurologic deficits or carpal tunnel syndrome in the cited records from 9/23/14 to warrant NCS or EMG. Therefore the determination is not medically necessary.

Lumbar epidural steroid injection at L2-3 and L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case the exam notes from 9/23/14 do not demonstrate a failure of conservative management or a clear evidence of a specific dermatomal distribution of radiculopathy. Therefore the determination is not medically necessary.