

Case Number:	CM14-0026112		
Date Assigned:	06/13/2014	Date of Injury:	12/27/2003
Decision Date:	07/29/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/28/2014

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 52-year-old female sustained an industrial injury on 12/27/03. The mechanism of injury was not documented. She underwent anterior cervical fusion at C6/7 and total disc replacement at C5/6 on 1/15/13. Records indicated use of a bone growth stimulator. Left shoulder pain was noted after using the bone growth stimulator. Records indicated the patient had been treated for neck, left shoulder, and low back pain. Subjective complaints included neck and left arm pain with numbness and tingling both arms, and low back pain radiating to both legs, with numbness. She reported 3 falls over the past year due to her legs giving out. Prior lumbar epidural steroid injections and diagnostic facet injections did not offer much benefit. The 2/6/14 treating physician report indicated that the patient was seen for follow-up of chronic neck and back pain, with increased neck and left shoulder pain. The patient was diagnosed with a left frozen shoulder in December 2013. She was still going to physical therapy with 5/12 sessions left. Left shoulder range of motion was improved; there was still a lot of pain. She was able to raise her left arm above shoulder level without using the other hand to lift it up. Review of systems documented complaints of headaches, balance problems, and poor concentration. The surgeon recommended new cervical MRI and x-rays which were performed in January. The 2/12/14 utilization review denied the request for orthopedic consult as guideline for surgical consultation had not been met. The request for an MRI of the brain was denied as there were no neurologic deficits on exam to warrant imaging and the concurrently certified neurosurgical evaluation had not been completed. The request for CT scan of the cervical spine was denied as a recent cervical x-ray was not documented as demonstrating equivocal evidence of solid fusion. The 3/10/14 treating physician report cited moderately severe left shoulder pain. The patient had completed 10/12 current physical therapy sessions and 6 prior sessions which provided temporary pain reduction. She had continued mobility issues. Review of systems documented complaints of headaches, balance

problems, and poor concentration. Physical exam documented left shoulder abduction 105, forward flexion 105, extension 45, and adduction 45 degrees. The left acromioclavicular joint was tenderness to palpation, with positive cross arm test. Neurologic higher function testing was within normal limits. The neurosurgeon report was reviewed and indicated the implants were in good position with no cervical spine compression noted. He recommended neurosurgical referral for follow-up of Chirai malformation and sella nodule, and orthopedic follow-up for the left frozen shoulder. Neurosurgical follow-up was recommended in 2-3 months to review CT scan of the neck and flexion/extension x-rays to check fusion status. Referral to an orthopedist was recommended for the continued left shoulder pain and range of motion limitations.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Consultation with Orthopedic Surgeon for the Left Shoulder: Overturned

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

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) Independent Medical Examinations and Consultations, page(s) 127.

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have been met. This patient has completed 10 recent physical therapy visits with some reported improvement in range of motion but persistent functional loss. Shoulder pain has increased and with only temporary short-lived improvement with therapy. The primary treating physician is a pain management specialist. Given the continued pain and range of motion loss, referral for an orthopedic consult for diagnosis and treatment recommendations seems reasonable. Therefore, this request for one consultation with an orthopedic surgeon for the left shoulder is medically necessary.

1 MRI of the Brain: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, update 11/18/13, web edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head, Magnetic Resonance Imaging (MRI).

Decision rationale: The California MTUS does not provide recommendations for this test in chronic conditions. The Official Disability Guidelines state that MRI of the head is indicated to determine neurologic deficits not explained by CT scan, to evaluate prolonged intervals of disturbed consciousness, and to define evidence of acute changes superimposed on previous trauma or disease. Guideline criteria have not been met. There is no evidence that this patient has had prolonged intervals of disturbed consciousness or previous head trauma or disease. There is no clinical evidence of red flag conditions or neurologic deficits to support the medical necessity of this test. A neurosurgical evaluation is pending to evaluate incidental findings of Chirai malformation and sella nodule. Balance issues and poor concentration are reported with no evidence of basic clinical assessment. There is no compelling reason to support the medical necessity of imaging at this time. Therefore, this request for one MRI of the brain is not medically necessary.

1 CT Scan of the Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck (web: updated 12/1713), Computed tomography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Complaints, Computed tomography (CT).

Decision rationale: The California Medical Treatment Utilization Schedule supports the use of CT scans and MRIs for initial evaluation of red flag conditions and to validate the diagnosis of nerve root compromise. The Official Disability Guidelines (ODG) states that MRI is the procedure of choice for patients who have had prior spinal surgery. Radiographic evaluation with plain films is required prior to imaging in patients with known cervical trauma. The ODG recommend that post-op evaluation of fusion be accomplished with x-rays. Repeat imaging (MRI or CT scan) is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Guideline criteria have been met. This request is for a CT scan for evaluation of fusion status as a follow-up to a recent cervical MRI and x-rays. Repeat x-rays have additionally been ordered. There is no compelling reason to support the medical necessity of routine imaging for assessment of fusion status. X-rays have also been ordered which are consistent with guidelines and should allow for adequate initial evaluation of the status of the fusion. Therefore, this request for one CT scan of the cervical spine is not medically necessary.