

Case Number:	CM14-0202208		
Date Assigned:	12/12/2014	Date of Injury:	10/20/1997
Decision Date:	01/29/2015	UR Denial Date:	11/02/2014
Priority:	Standard	Application Received:	12/03/2014

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 injured worker (IW) is a 61-year-old man with a date of injury of October 20, 10997 when he was lifting absorbent bags over the side of the bed. He felt a sharp pain in the left shoulder and left elbow. The injured worker's working diagnoses are cervical sprain for which no diagnostics have been done associated with radiculitis along the left upper extremity; midback sprain related to donor site scar sensitivity, not associated with spasms; impingement syndrome of the shoulder on the right status post decompression, labral repair, rotator cuff repair, and biceps tendon release; lateral epicondylitis on the right, stable; carpal tunnel syndrome on the right, stable; impingement syndrome of the shoulder on the left status post decompression followed by reevaluation and open distal clavicle excision, although an arthroscopy did not show a tear in the labrum at that time; elbow joint injury resulting in multiple procedures consisting of soft tissue releases, fenestration of distal humerus, excision of tip of the coronoid process, ligamentous surgery to stabilize the medial collateral ligament, lateral epicondylar release, medial epicondylar release, ulnar nerve transposition, the latter being the first procedure in 1998, the soft tissue intervention to the elbow being in the year 1999, 2000, and 2001 followed by total elbow replacement in 2000 and 2003; chronic pain syndrome; triggering along the ringer on the right; and pulmonary fibrosis. The IW has been hospitalized multiple times for pneumonia and pulmonary fibrosis and use of antibiotics. Pursuant to treating physician's progress note from the [REDACTED] dated October 21, 2014, the IW reports he got out of bed quickly, attempting to use the bathroom and passed out twice. Since passing out, he has had surgical spinal pain with numbness and tingling in his right face and his right neck. The IW had revised total elbow in place and a latissimus dorsi flap to cover what was skin loss from a prior infection and also a latissimus dorsi muscle flap for an absent triceps tendon. The last elbow procedure was to try to tighten the triceps tendon. He is also known to have bilateral

rotator cuff tears. With the antibiotics to treat the elbow infections, he lost most of his hearing. Physical examination reveals right compared to left shoulder flexion is 120/90 degrees, and external rotation 30/5 degrees. He is weak in the supraspinatus and infraspinatus in both shoulders. He does not have active elbow extension against gravity, but he does have active extension in the absence of gravity with his muscle tendon transfer. The provider is recommending the IW see an ENT doctor for his hearing loss, and an MRI of his cervical spine. He is recommending the IW see the appropriate orthopedic and neurosurgeon for his cervical spine radiculopathy. There is an Initial Physical Therapy Evaluation in the medical record dated May 28, 14. The note states that the IW will be certified for 36 visits over the certification period of May 27, 2014 to August 25, 2015. There was no other physical therapy (PT) noted in the medical record for review. There was no evidence of objective functional improvement associated with physical therapy. According to a follow-up note by the primary treating physician dated September 22, 2014, the IW present with persistent pain in the neck, both shoulders, left elbow, and left wrist and has completed occupational therapy. The current request is for occupational therapy (12 sessions) to the left elbow, MRI to the cervical spine, consultation with ENT, Orthopedic consultation for cervical spine, and consultation with neurosurgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation with neurosurgery: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Consultation and independent medical examinations, page 127

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, Chapter 7, Page 127. Official Disability Guidelines (ODG); Pain Section, Office Visit

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, consultation with neurosurgery is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. If the diagnosis is uncertain or extremely complex when the plan of care may benefit from additional expertise, consultation is appropriate. In this case, the injured worker's working diagnoses are cervical sprain for which no diagnostics have been done associated with radiculitis along the left upper extremity; mid back sprain; impingement shoulder of syndrome, right, status post the compression, labral tear, rotator cuff repair and biceps tendon release; lateral epicondylitis on the right; carpal tunnel syndrome on the right; impingement syndrome left shoulder status post the compression followed by reevaluation and open distal clavicle excision; elbow joint injury with multiple procedures, and fenestration of distal humerus. The injured worker was seen October 21, 2014 at the [REDACTED]. The injured worker had a revised total elbow and the latissimus dorsi muscle flap to cover what was skin loss from a prior infection and muscle flap for absent triceps tendon. He has known bilateral rotator cuff tears. Physical examination

includes a brief examination of the shoulder. There were no other clinical findings noted. The recommendations were an ENT doctor for his hearing loss, MRI of his cervical spine, and appropriate orthopedic and neurosurgeon for his cervical spine radiculopathy. There is no documentation indicating a clinical rationale or clinical indication for the neurosurgeon. Simply stating cervical spine radiculopathy is not a clinical indication for neurosurgical consultation. Consequently, absent the appropriate clinical indication of clinical rationale, neurosurgical evaluation is not medically necessary.

Orthopedic consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Consultation and independent medical examinations, page 127

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, Chapter 7, Page 127 Official Disability Guidelines (ODG); Pain Section, Office Visit

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, orthopedic consultation is not medically necessary. The need for clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. If the diagnosis is uncertain or extremely complex or when the plan of care may benefit from additional expertise, consultation is appropriate. In this case, the injured worker's working diagnoses are cervical sprain for which no diagnostics have been done associated with radiculitis along the left upper extremity; mid back sprain; impingement shoulder of syndrome, right, status post the compression, labral tear, rotator cuff repair and biceps tendon release; lateral epicondylitis on the right; carpal tunnel syndrome on the right; impingement syndrome left shoulder status post the compression followed by reevaluation and open distal clavicle excision; elbow joint injury with multiple procedures, and fenestration of distal humerus. The injured worker was seen October 21, 2014 at the [REDACTED]. The injured worker had a revised total elbow and the latissimus dorsi muscle flap to cover what was skin loss from a prior infection and muscle flap for absent triceps tendon. He has known bilateral rotator cuff tears. Physical examination includes a brief examination of the shoulder. There were no other clinical findings noted. The recommendations were an ENT doctor for his hearing loss, MRI of his cervical spine, and appropriate orthopedic and neurosurgeon for his cervical spine radiculopathy. There is no documentation indicating a clinical rationale or clinical indication for the orthopedic surgeon. Simply stating cervical spine radiculopathy is not a clinical indication for an orthopedic consultation. Consequently, absent the appropriate clinical indication of clinical rationale, orthopedic consultation is not medically necessary.

Consultation with ENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Consultation and independent medical examinations, page 127

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, Chapter 7, Page 127 Official Disability Guidelines (ODG); Pain Section, Office Visit

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, ENT consultation is not medically necessary. The need for clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. If the diagnosis is uncertain or extremely complex or when the plan of care may benefit from additional expertise, consultation is appropriate. In this case, the injured worker's working diagnoses are cervical sprain for which no diagnostics have been done associated with radiculitis along the left upper extremity; mid back sprain; impingement shoulder of syndrome, right, status post the compression, labral tear, rotator cuff repair and biceps tendon release; lateral epicondylitis on the right; carpal tunnel syndrome on the right; impingement syndrome left shoulder status post the compression followed by reevaluation and open distal clavicle excision; elbow joint injury with multiple procedures, and fenestration of distal humerus. The injured worker was seen October 21, 2014 at the [REDACTED]. The injured worker had a revised total elbow and the latissimus dorsi muscle flap to cover what was skin loss from a prior infection and muscle flap for absent triceps tendon. He has known bilateral rotator cuff tears. Physical examination includes a brief examination of the shoulder. There were no other clinical findings noted. The recommendations were an ENT doctor for his hearing loss, MRI of his cervical spine, and appropriate orthopedic and neurosurgeon for his cervical spine radiculopathy. There is no documentation indicating a clinical rationale or clinical indication for the ENT consultation. Simply stating hearing loss is not a clinical indication for an ENT consultation. There was no examination of the ears or history referencing the ears and hearing loss. Consequently, absent the appropriate clinical indication of clinical rationale and clinical history, ENT consultation is not medically necessary.

MRI of the cervical spine: Upheld

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

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

Decision rationale: Pursuant to the Official Disability Guidelines, MRI cervical spine is not medically necessary. MRIs are not recommended for patients who are alert, have never lost consciousness, or not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings. Patients not falling into this category should have 3 view cervical radiographs. The Official Disability Guidelines enumerate

the indications for cervical spine imaging. In this case, the injured worker's working diagnoses are cervical sprain for which no diagnostics have been done associated with radiculitis along the left upper extremity; mid back sprain; impingement shoulder of syndrome, right, status post the compression, labral tear, rotator cuff repair and biceps tendon release; lateral epicondylitis on the right; carpal tunnel syndrome on the right; impingement syndrome left shoulder status post the compression followed by reevaluation and open distal clavicle excision; elbow joint injury with multiple procedures, and fenestration of distal humerus. The injured worker was seen October 21, 2014 at the [REDACTED]. The injured worker had a revised total elbow and the latissimus dorsi muscle flap to cover what was skin loss from a prior infection and muscle flap for absent triceps tendon. He has known bilateral rotator cuff tears. Physical examination includes a brief examination of the shoulder. There were no other clinical findings noted. The recommendations were an ENT doctor for his hearing loss, MRI of his cervical spine, and appropriate orthopedic and neurosurgeon for his cervical spine radiculopathy. There is no documentation indicating a clinical rationale or clinical indication for the cervical spine MRI. Simply stating cervical radiculopathy is not a clinical indication for a cervical spine MRI. There was no examination of the cervical spine, a neurological examination or neurologic findings. Consequently, absent the appropriate clinical indication, clinical rationale and clinical examination, cervical spine MRI is not medically necessary.

Occupational therapy to the left elbow; 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow Section, Physical Therapy

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, occupational therapy to the left elbow 12 sessions is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). The guidelines enumerated the frequency and duration of physical therapy according to does the state and or surgery. In this case, the date of last surgery was July 15, 2013. The injured worker underwent revision to custom total elbow replacement with pressfit humoral, opponent and cemented long stem on their comp opponent; capsular excision and creation of combination triceps latissimus tendon for triceps function; advancement of latissimus of triceps; and harvest multiple cultures. The injured worker was certified for physical therapy from May 15, 2014 two August 15, 2014 at 1 to 2 sessions per week times three months. The documentation indicated 36 sessions of physical therapy were approved. There is no documentation in the medical record indicating objective functional improvement or therapy progress notes in the medical record. Consequently, absent a clinical indication for additional physical therapy, documentation of objective functional improvement as a reflection of 36 prior physical therapy sessions, occupational therapy to the left elbow 12 sessions is not medically necessary.