

<b>Case Number:</b>	CM14-0216722		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Section 1: The injured worker is a 56-year-old female who reported an injury on 08/31/2011. The mechanism of injury occurred over time while she was assembling chairs. Her diagnoses include status post acromial decompression of the C4-5 and C5-6 and left shoulder impingement, possible rotator cuff tear. Her past treatments included chiropractic care, physical therapy, aquatic therapy, surgery, and medications. Pertinent diagnostic studies included a left shoulder MRI, performed on 10/20/2014, which revealed a complex anterosuperior labral tear. The patient also had a left shoulder CT, performed on 10/20/2014, which revealed a status post uncomplicated CT of the left shoulder. A cervical spine MRI was performed on 08/11/2014, which revealed effusion from the C4-6, C3-4 mild spinal cord flattening centrally with stenosis, and mild left foraminal stenosis; C4-5 full decompression and central neural foramina; C5-6 central canal left foraminal decompression with moderate right foraminal stenosis; and no frank disc extrusion, central canal stenosis, or intrinsic spinal cord pathology throughout the study. The injured worker's pertinent surgical history included a cervical fusion from C4-6. On 09/25/2014, the injured worker complained of neck pain and bilateral shoulder pain. The physical examination of the cervical spine revealed no evidence of atrophy or wasting, recent trauma, ecchymosis, or visible masses. The cervical range of motion revealed flexion at 10 degrees bilaterally and extension 10 degrees bilaterally. The injured worker also was nontender to light/deep palpation and there were no palpable trigger points in the anterior or posterior cervical musculature. The injured worker was also noted to have intact motor strength in the upper extremities along with intact sensation and deep tendon reflexes. Relevant medications

were noted to include ibuprofen. The treatment plan included associated surgical services: pain pump, cold unit rental times 7 days, CAT scan (cervical spine), and MRI of cervical spine. A rationale was not provided for review. A Request for Authorization form was not submitted.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Associated surgical service: Pain pump: 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), Shoulder

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative pain pump.

**Decision rationale:** The request for a pain pump is not medically necessary. According to the Official Disability Guidelines, postoperative pain pumps are not recommended. Based on the lack of documentation that were supporting the use of postoperative pain pumps, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Associated surgical service: Cold Unit rental for 7 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 (ODG), Shoulder ; AM J Sports Med. 1996 Mar-Apr; 24 (2): 193-5

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Continuous flow cryotherapy.

**Decision rationale:** The request for a cold unit rental times 7 days is not medically necessary. According to the Official Disability Guidelines, continuous flow cryotherapy units are not recommended in the neck. However, the guidelines state this equipment may be recommended as an option after surgery postoperatively for 7 days. Based on the guidelines not supporting the use of the continuous flow cryotherapy unit in the neck, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

**Associated surgical service: CAT scan of the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for a CAT scan cervical spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, patients presenting with true neck or low back problems do not need special studies unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. In addition, the criteria for ordering imaging studies include: an emergence of a red flag, physiological evidence of a tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The injured worker was indicated to have chronic cervical pain with decreased range of motion. However, the neurologic examination was noted to be within normal values. Based on the above, the request is not supported by the evidence based guidelines as there was a lack of documentation of a specific nerve compromise on the neurologic exam. As such, the request is not medically necessary.

**Associated surgical service: MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** The request for an MRI of the cervical spine is not medically necessary. The Official Disability Guidelines state that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker was indicated to have undergone a cervical spine procedure. The injured worker was also noted to have chronic cervical pain; however, there was a lack of documentation in regard to significant changes in symptoms and/or findings suggestive of significant pathology. Additionally, the documentation indicated the neurological examination was within normal values. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.