

Case Number:	CM15-0017138		
Date Assigned:	02/04/2015	Date of Injury:	04/28/2012
Decision Date:	05/26/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/28/2015

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:

The injured worker is a 44-year-old female who reported an injury on 04/20/2012. The mechanism of injury was not provided. The injured worker underwent an MRI of the left shoulder on 06/22/2012, which revealed a small amount of joint effusion. There was evidence of impingement with downsloping of the acromion impinging on the supraspinatus tendon and the rotator cuff. The injured worker underwent an MRI of the cervical spine on 09/29/2009, which revealed a mild disc bulging and spurring at C6-7 with mild left C6-7 foraminal stenosis with minimal disc bulges at C3-6. There was a Request for Authorization submitted for review dated 12/10/2014. The documentation of 12/10/2014 revealed the injured worker had complaints of left shoulder pain and neck pain. The injured worker had decreased range of motion of the cervical spine with tenderness to palpation at C5-6 spinous processes and right trapezius muscles. The Adson's test was negative. The cervical compression test was positive. The cervical distraction test was positive and shoulder abduction could not be performed on the left. There was decreased range of motion of the left shoulder. There was tenderness to palpation of the acromioclavicular joint, anterior glenoid, and greater tuberosity. The Neer's and Hawkins tests could not be performed, as there was an inability to access the shoulder abduction. The diagnoses included left rotator cuff tear and left shoulder adhesive bursitis. The treatment plan included diagnostic testing, MRI of the cervical spine and left shoulder, electro diagnostic testing, and arthroscopic examination of the left shoulder with repair versus debridement of the anterior glenoid labral tear with acromioplasty.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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, Magnetic resonance imaging (MRI).

Decision rationale: The Official Disability Guidelines indicate that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms or findings of significant pathology. The clinical documentation submitted for review failed to provide documentation of a significant change in symptoms or findings of a significant pathology to support a repeat MRI. Given the above, the request for MRI of the cervical spine is not medically necessary.

MRI of the left shoulder: Upheld

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 Official Disability Guidelines (ODG) Shoulder chapter, Magnetic resonance imaging (MRI).

Decision rationale: The Official Disability Guidelines indicate that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms or findings of significant pathology. The clinical documentation submitted for review failed to provide documentation of a significant change in symptoms or findings of a significant pathology to support a repeat MRI. Given the above, the request for MRI of the left shoulder is not medically necessary. The prior MRI, per the supplied documentation, indicated the injured worker had a small amount of joint effusion with evidence of impingement with down sloping of the acromion impinging on the supraspinatus tendon in the rotator cuff. There as well a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for MRI of the left shoulder is not medically necessary.

Electro diagnostic testing upper extremities: Upheld

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

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

Decision rationale: The American College of Occupational and Environmental Medicine states that Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There should be documentation of 3 - 4 weeks of conservative care and observation. The clinical documentation submitted for review indicated the injured worker had a positive cervical compression test and cervical distraction test. There was a lack of documentation of myotomal and/or dermatomal deficits. There was a lack of documentation of a failure of conservative care and specific conservative care that was directed at the bilateral upper extremities. Additionally, this request was submitted for review with a request for an EMG/NCS of the bilateral upper extremities, which would be considered the same. There was a lack of documentation indicating a necessity for both electro diagnostic studies and EMG/NCS, as they are the same. Given the above, the request for electro diagnostic testing upper extremities is not medically necessary.

EMG/NCS of the upper extremities: Upheld

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

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

Decision rationale: The American College of Occupational and Environmental Medicine states that Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There should be documentation of 3 - 4 weeks of conservative care and observation. The clinical documentation submitted for review indicated the injured worker had a positive cervical compression test and cervical distraction test. There was a lack of documentation of myotomal and/or dermatomal deficits. There was a lack of documentation of a failure of conservative care and specific conservative care that was directed at the bilateral upper extremities. Additionally, this request was submitted for review with a request for electro diagnostic testing upper extremities, which would be considered the same. There was a lack of documentation indicating a necessity for both electro diagnostic studies and EMG/NCS, as they are the same. Given the above, the request for EMG/NCS of the bilateral upper extremities is not medically necessary.

Arthroscopic examination of the left shoulder with repair vs debridement of the anterior glenoid labral tear with acromioplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery for SLAP lesions.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. For injured workers with a partial thickness or small full thickness tear, impingement surgery is reserved for cases failing conservative care therapy for 3 months and who have imaging evidence of rotator cuff deficit. For surgery for impingement syndrome, there should be documentation of conservative care including cortisone injections for 3 to 6 months before considering surgery. The clinical documentation submitted for review failed to provide documentation of an official MRI. There was a lack of documentation indicating the injured worker had impingement, as the injured worker could not perform shoulder abduction. The official MRI was not provided for review. There was a lack of documentation of a failure of conservative care and the duration of conservative care specifically for the left shoulder. There was as lack of documentation of a cortisone injection. The ACOEM Guidelines do not specifically address labrum surgery. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that the surgery for a SLAP lesion is recommended for a type 2 or type 4 lesions, history, physical examination and imaging should indicate pathology, and the definitive diagnosis of SLAP lesion is diagnostic arthroscopy. The surgical intervention for impingement was found to be not medically necessary and as such, this portion of the request would not be medically necessary. Additionally, there was no official MRI submitted for review. Given the above, the request for arthroscopic examination of the left shoulder with repair vs. debridement of the anterior glenoid labral tear with acromioplasty is not medically necessary.