

<b>Case Number:</b>	CM15-0091742		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	05/08/2013
<b>Decision Date:</b>	06/18/2015	<b>UR Denial Date:</b>	04/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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: Emergency 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 61 year old male patient who sustained an injury on 05/08/2013. The accident was described as having had tripped and fallen rolling down a hill twisting the knee with resulting right knee injury. He reported the injury was evaluated and underwent a course of physical therapy (40 sessions 11/2013-02/2014) along with having the knee drained. At one point, surgery was recommended but deferred, and finally on 09/09/2013 he underwent intervention. He has also had injection treating the shoulder issue with mild temporary relief. An initial pain evaluation visit dated 02/06/2015 reported present complaints of pain in the neck, and left shoulder. His neck pain radiates down to the left upper extremity. He also complains of headaches. He states avoiding work, activities and or exercises due to pain limitations. Current medications are; Ibuprofen 800mg and Norco 7.5/.25mg. Radiography study of the cervical spine performed on 03/24/2014 revealed post-surgical changes affect the spinous processes of C2, C3 and C4. There is bony fusion anteriorly from C2-C6. There is loss of the normal cervical lordosis with slight flexion deformity of the neck. No evidence for instability or spondylolisthesis with flexion and extension views. On 03/26/2014, he underwent a magnetic resonance imaging study of the left shoulder, which revealed rotator cuff tendinosis, a small near full-thickness crescentic appearing tear is present in the distal supraspinatus tendon; advanced glenohumeral joint osteoarthritis with loose osseous bodies, glenohumeral joint effusion and synovitis; scattered labral tearing, and degeneration, acromioclavicular joint arthritis and joint effusion. On 03/28/2014, he underwent a magnetic resonance imaging scan of the cervical spine that showed interval posterior decompression from C2 down to C4.

Ossification of posterior longitudinal ligament; superimposed multi-level degenerative disc disease with the largest posterior disc bulge/herniation at C7-T1 on the left and multi-level foraminal narrowing's. Radiography study initially performed on the right knee on 04/22/2010 revealed right suprapatellar joint effusion. On 05/08/2013 he underwent a computerized tomography study of the head that revealed mild left periorbital soft tissue swelling with possible small soft tissue hematoma; no acute intracranial process. A magnetic resonance imaging study of the cervical spine on 05/14/2013 showed C2-3 concentric uncovertebral hypertrophy with superimposed posterior central disc osteophyte complex producing severe central canal narrowing.

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

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

**Referral to a neurosurgeon, cervical spine, per 02/06/15 order:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Red flag indications, Chronic Pain Treatment Guidelines Page 1, Introduction Page(s): 1.

**Decision rationale:** The requested Referral to a neurosurgeon, cervical spine, per 02/06/15 order, is medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8, Neck and Upper Back Complaints, Assessing red flags and indications for immediate referral, recommend specialist consultation with "physical exam evidence of severe neurologic compromise that correlates with the medical history and test results"; and California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has pain in the neck, and left shoulder. His neck pain radiates down to the left upper extremity. He also complains of headaches. He states avoiding work, activities and or exercises due to pain limitations. The treating physician has documented Radiography study of the cervical spine performed on 03/24/2014 revealed post-surgical changes affect the spinous processes of C2, C3 and C4. There is bony fusion anteriorly from C2-C6. There is loss of the normal cervical lordosis with slight flexion deformity of the neck. No evidence for instability or spondylolisthesis with flexion and extension views. On 03/26/2014, he underwent a magnetic resonance imaging study of the left shoulder, which revealed rotator cuff tendinosis, a small near full-thickness crescentic appearing tear is present in the distal supraspinatus tendon; advanced glenohumeral joint osteoarthritis with loose osseous bodies, glenohumeral joint effusion and synovitis; scattered labral tearing, and degeneration, acromioclavicular joint arthritis and joint effusion. On 03/28/2014, he underwent a magnetic resonance imaging scan of the cervical spine that showed interval posterior decompression from C2 down to C4. Ossification of posterior longitudinal ligament; superimposed multi-level degenerative disc disease with the largest posterior disc bulge/herniation at C7-T1 on the left and multi-level foraminal narrowing's. The treating physician has documented sufficient positive interval diagnostic changes to establish the medical necessity for a neurosurgeon consult for the cervical spine. The criteria noted above

having been met, Referral to a neurosurgeon, cervical spine, per 02/06/15 order is medically necessary.

**Treatment with an orthopedic surgeon, left shoulder, per 02/06/15 order:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, Page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 9 Shoulder Complaints Page(s): Red flag conditions, Chronic Pain Treatment Guidelines Page 1, Introduction Page(s): 1.

**Decision rationale:** The requested Treatment with an orthopedic surgeon, left shoulder, per 02/06/15 order , is medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 9, Shoulder Complaints, Assessing red flags and indications for immediate referral, recommend specialist consultation with "physical exam evidence of severe neurologic compromised that correlates with the medical history and test results"; and California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has pain in the neck, and left shoulder. His neck pain radiates down to the left upper extremity. He also complains of headaches. He states avoiding work, activities and or exercises due to pain limitations. The treating physician has documented Radiography study of the cervical spine performed on 03/24/2014 revealed post-surgical changes affect the spinous processes of C2, C3 and C4. There is bony fusion anteriorly from C2-C6. There is loss of the normal cervical lordosis with slight flexion deformity of the neck. No evidence for instability or spondylolisthesis with flexion and extension views. On 03/26/2014, he underwent a magnetic resonance imaging study of the left shoulder, which revealed rotator cuff tendinosis, a small near full-thickness crescentic appearing tear is present in the distal supraspinatus tendon; advanced glenohumeral joint osteoarthritis with loose osseous bodies, glenohumeral joint effusion and synovitis; scattered labral tearing, and degeneration, acromioclavicular joint arthritis and joint effusion. On 03/28/2014, he underwent a magnetic resonance imaging scan of the cervical spine that showed interval posterior decompression from C2 down to C4. Ossification of posterior longitudinal ligament; superimposed multi-level degenerative disc disease with the largest posterior disc bulge/herniation at C7-T1 on the left and multi-level foraminal narrowing's. The treating physician has documented sufficient positive interval diagnostic changes to establish the medical necessity for an orthopedic consult for the shoulder. The criteria noted above having been met, Treatment with an orthopedic surgeon, left shoulder, per 02/06/15 order is medically necessary.