

Case Number:	CM13-0016937		
Date Assigned:	10/11/2013	Date of Injury:	12/01/2008
Decision Date:	01/21/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	08/27/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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 patient is a 30-year old who sustained a work injury on 12/01/08 as she was helping deal with a combative patient as a paramedic. She sustained an injury to her right shoulder. The patient does not recall any obvious dislocation; however, she states that she may have banged it against a hard object. However, she did notice having immediate pain. There is no history of any dislocation or reduction maneuvers at any point in time. She is Status post right shoulder arthroscopy, debridement of partial rotator cuff tear, subacromial decompression and capsular shrinkage on 8/24/09. 6/25/09 note A two-view x-ray series of the cervical spine were obtained and reveal evidence of reversal of the normal cervical lordosis. otherwise, she has mild degenerative disc disease. MRI CERVICAL SPINE WITHOUT CONTRAST 7/20/2009 CLINICAL HISTORY: Right shoulder pain with arm numbness and weakness. Injury on 02/01/00. FINDINGS~ There is slight reversal of the cervical lordosis at C3-4. The vertebral bodies demonstrate normal marrow signal and height. There is some loss of signal in the C2-3 through C6-7 discs, without significant loss in height. The cervical cord and craniocervical junction are normal. C2-3, C3-4: No significant protrusion, central canal or neural foraminal narrowing is present. C4-5: There is a mild, annular bulge with a small central protrusion, measuring 2-3 mm. The thecal sac is slightly effaced, and there is slight encroachment on the proximal right neural foramen. No significant impingement on the cervical is demonstrated at C5-6, C6-7, C7-T1: No significant protrusion, central canal or neural foraminal narrowing is present IMPRESSION: 1. Mild annular bulge and small central protrusion at C4-5, slightly effacing the thecal sac and minimally encroaching onto the proximal right neural foramen. 2. Mild reversal of the normal Upper cervical lordosis, This finding is nonspecific but may be associated with mild spasm Per documentation

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

Decision rationale: Cervical MRI is medically appropriate in this patient. Documentation from 8/19/13 indicate on physical exam that : "Lateral rotation and extension of the spine produces concordant pain in the affected area." Additionally patient demonstrated "Sensation of the region reveals dystesthetic sensations throughout the affected area " Per MTUS/ACOEM guidelines these would qualify as "physiologic evidence of tissue insult or neurologic dysfunction." Guidelines state that "Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." Furthermore although NCS/EMG was reported negative it is possible that patient could have cervical radiculitis (dorsal root ganglion compromise) vs radiculopathy (ventral root compromise.) In pure dorsal root compromise NCS/EMG can be negative. OCCUPATIONAL MEDICINE PRACTICE GUIDELINES-page 178,179. . For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: - Emergence of a red flag - Physiologic evidence of tissue insult or neurologic dysfunction - Failure to progress in a strengthening program intended to avoid surgery - Clarification of the anatomy prior to an invasive procedure Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. 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. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is u