

<b>Case Number:</b>	CM13-0060566		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/11/2009
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	11/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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, Occupational/Internal 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:

Patient is an injured worker status post carpal tunnel release. Date of injury was 10-11-2009. Qualified Medical Evaluation (QME) 06-22-2012 report provided a case summary. History obtained from the claimant: Patient was injured at work on October 11, 2009 when he performed prolonged reaching overhead and developed fatigue in his right shoulder. He later lifted a heavy power cable and noted pain in the right shoulder. Surgeries: One right shoulder and left ulnar nerve transposition. He did undergo a right carpal tunnel release in 1999 through his private insurance without residual. Status post right shoulder arthroscopic SLAP repair February 11, 2010. Status post left ulnar nerve transposition with medial epicondylar debridement/reattachment, September 19, 2011. EMG and nerve conduction study of the left upper extremity and cervical paraspinals of June 21, 2011 showed a mild left carpal tunnel syndrome and significant entrapment neuropathy of the left ulnar nerve at the elbow. Primary treating physician's progress report (PR-2) 05-30-2013 documented subjective complaints: The patient feels symptoms in his left upper extremity with worsening numbness and tingling as well as pain in his hand. Physical examination: Extremities: Examination is consistent with left carpal tunnel syndrome. He is noted to have positive Tinel's sign, positive compression sign and positive Phalen's sign. Clinical diagnosis: Left carpal tunnel syndrome, confirmed by EMG's June 2011. Plan: Recommended proceeding with possible left carpal tunnel release. Qualified Medical Evaluation (QME) 07-11-2013 report documented left shoulder condition and right carpal tunnel release surgery. Left shoulder sprain with impingement and MRI scan evidence of mild glenohumeral degenerative changes, small partial articular surface tear of the supraspinatus tendon, posterior superior paralabral cyst consistent with occult labral tear. Status post pre-existing right carpal tunnel release. PR-2 report 08-08-2013 documented left carpal tunnel syndrome. Left carpal tunnel release surgery was recommended. Operative report 09-06-2013

documented the diagnosis of left carpal tunnel syndrome. Procedures performed: left carpal tunnel release, median nerve block. "The patient tolerated the procedure well, awakened and transferred to recovery room in stable and satisfactory condition." Progress note /16/2013 documented post-operative condition. Subjective: The patient returns S/P Carpal Tunnel Release. Date of Surgery: 09/06/2013. Surgical Procedure: Left carpal tunnel release. Median nerve block. Left Wrist Examination: Examination today reveals the incision to be healing nicely with no problems being evident. There is mild swelling in the area but no drainage or induration. There is also mild swelling of the fingers. Brief neurovascular examination does not reveal any deficit. The patient also has pain in the bilateral shoulders and other joints. Diagnosis: S/P Carpal Tunnel Release. Treatment Plan: a course of occupational therapy was recommended. Flexeril 10 mg tablets were prescribed. Progress note 10/7/2013 reported that the patient returns status post left carpal tunnel release. Patient is concerned because he has significant weakness in his bilateral hands. Date of Surgery: 9/6/2013. Procedures performed: left carpal tunnel release, median nerve block. Left wrist examination: The patient is noted to have significant wasting and atrophy in his bilateral hands. He is also noted to have swelling in all of the joints in his bilateral hands that has been a change since his last visit. The patient has weakness with abduction bilaterally. His first dorsal interossei reflect wasting bilaterally. Impression: status post left carpal tunnel release with signs and symptoms consistent with possible rheumatological disorder versus myelopathy, bilateral upper extremities. Request for authorization (RFA) 10-10-2013 requested MRI c-spine. Diagnosis was bilateral carpal tunnel syndrome. Imaging request form 10-07-2013 requested C-spine MRI, rule out myelopathy, reason for test bilateral hand weakness and atrophy. Referral/consult request 10-07-2013 documented referral to neurologist for bilateral EMG nerve conduction study. Reason for referral: bilateral hand weakness and interossei wasting. Utilization review dated 11-11-2013 recommended non-certification of the request for MRI C-spine.

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

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

**CERVICAL SPINE MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Table 8-8. Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints.

**Decision rationale:** (ACOEM) Neck and Upper Back Complaints Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints: MRI is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. Medical records documented right shoulder surgery 02-11-2010, right carpal tunnel release surgery in 1999, left ulnar nerve transposition surgery 09-19-2011, left carpal tunnel release surgery 09-06-2013. Medical records documented left shoulder sprain with impingement and MRI scan evidence of mild glenohumeral degenerative changes, small partial articular surface tear of the supraspinatus

tendon, posterior superior paralabral cyst consistent with occult labral tear. EMG and nerve conduction study of the left upper extremity and cervical paraspinals of June 21, 2011 showed a mild left carpal tunnel syndrome and significant entrapment neuropathy of the left ulnar nerve at the elbow. Operative report 09-06-2013 documented the performance of left carpal tunnel without complications. Medical records dated 06-22-2012, 05-30-2013, 07-11-2013, 08-08-2013, 09-06-2013, and 09-16-2013 did not document a cervical spine condition. Progress note 10/7/2013 documented the patient's complaint of weakness in bilateral hands. Physical examination reported wasting and atrophy in bilateral hands. Swelling in all of the joints in bilateral hands was noted, weakness with abduction bilaterally, first dorsal interossei reflect wasting bilaterally. No physical examination of the remainder of the upper extremities was documented. No additional neurologic examination was documented. No physical examination of the cervical spine was documented. There was no documentation of new cervical spine injury. Medical records do not document physical examination of the cervical spine. There is no documentation of physical examination findings of cervical nerve root compromise. Per MTUS and ACOEM guidelines, the medical necessity of MRI of the cervical spine is not supported by the medical records. Therefore, the request for MRI C spine is not medically necessary.