

Case Number:	CM13-0072330		
Date Assigned:	01/08/2014	Date of Injury:	09/04/2011
Decision Date:	10/24/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	12/30/2013

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 Orthopedics and is licensed to practice in Arizona. 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:

This 41-year old male valet parker for a hotel company sustained his first work-related injury in March of 2011 and second injury in MVA (when he crashed guest car into a cement pole and sustained left shoulder dislocation on 9/4/2011). No detail of specific detail available. There is minimal documentation of time from day of injury to period when he had aggravated complaints related to neck, left shoulder and arm. He had multiple consults regarding treatment of his left shoulder post-dislocation and possible thoracic outlet syndrome (TOS). The cervical complaints were reported to worsen since December 2013 (numbness, tingling sensation and left arm weakness). Range of motion cervical spine was also decreased. First report of occupational injury was by Chiropractor on 1/15/2013, handwritten and difficult to read. Treatment at the time consisted of physical therapy and weekly massages. Most recent MRI of cervical spine was done on 6/7/2012 and reported degenerative disc disease, small disc protrusion C6-7 and this was unchanged from previous MRI. No radiculopathy or cord compression. In reviewing available documentation, there was no mention of radiculopathy symptoms or findings of progressive neurologic deficit or additional red flags. Physical examination revealed minimal documentation of cervical findings. Most documentation/findings were related to shoulder and TOS. On 2/28/2013, he complained of flare up of neck and arm pain (VAS (visual analog scale score reported as 8-9/10), weakness and paralysis (3/28/2013). Also mentioned weak grip and left arm pain (minimal detail). On 4/15/2013 he complained of left-sided neck pain, painless range of neck motion and motor weakness at 4/5. Deep tendon reflexes are normal & symmetrical. No other physical findings documented. Treatment rendered since day of injury was aimed at shoulder and thoracic outlet syndrome and included (mention made of but minimal detail given): EMG/NCV's left upper extremity (2/13/2012); MRI cervical spine (6/7/2012); MRI brachial plexus (6/27/2012); Physical therapy (some improvement); Chiropractic manipulation-

Acupuncture; Pain management; Medrol dose Pak; Nycenta; Lidoderm patches; Trigger point injections neck was partially beneficial; T.E.N.S., ultra sound, Cryo-therapy and moist hot packs (modalities); Psychology sessions (Cognitive behavioral treatment); Epidural interlaminar injection C7-T1 was initially denied but eventually approved (12/11/2013) and was done on 12/27/2013. No benefit reported; Diagnostic studies consisted of MRI cervical spine done 3/20/2012 & 2/7/201 revealed disc protrusion C5-6 and C6-7. Scalenus muscle block was done 2 times (non-diagnostic).Diagnosis was documented as, anterior dislocation left shoulder; Most recently as myo-fascial pain with chronic spasms; Cervical radiculopathy (729.2); Degenerative cervical disc (722.4) Differential diagnosis given as on 4/10/2013: Rotator cuff tear; Frozen shoulder; Chronic regional pain syndrome; Primary brachial plexus injury. Work status: Temporary Totally Disabled (TTD).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165, 180,177-178 , 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Magnetic Resonance Imaging.

Decision rationale: ACOEM states "Evidence-based medicine focuses on the need for health care providers to rely on a critical appraisal of available scientific evidence rather than clinical opinion or anecdotal reports in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision making." No clinical radiculopathy was documented. MTUS, as cited, states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing." On review of the current medical reporting, there is no documentation of positive objective findings of radiculopathy, inclusive of sensory dysfunction in a dermatomal pattern, motor dysfunction, abnormal reflexes or convincing MRI findings. According to ODG repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neuro-compression, recurrent disc herniation). MRI imaging studies are valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions are suspected like tumor, infection, and fracture, or for clarification of anatomy prior to surgery. MRI is the test of choice for patients who have had prior back surgery. Patients with neck pain accompanied by normal radiographs and neurologic signs or symptoms should undergo magnetic resonance imaging if: 1. Severe or progressive neurologic deficit is present; 2.Neck trauma, acute or chronic is suspected; 3.Neck pain accompanied by bone destruction; 4. Chronic neck pain with diagnosed spondylosis plus specific neurologic signs or symptoms. None of these criteria were clinically found. Therefore, the request for an MRI of the cervical spine is not medically necessary and appropriate.

spine surgeon evaluation and treatment: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, Chronic Pain Treatment Guidelines Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Magnetic Resonance Imaging.

Decision rationale: ACOEM states that in absence of red flags primary care and occupational physicians can manage neck problems. The patient has persistent and, according to clinical notes, severe arm symptoms. He also has unresolved symptoms (described as radiculopathy) after receiving what is described as conservative therapy. ODG recommends case-by-case decision on surgical consult due to small available randomized trials to support more definitive guideline(s). Therefore, the request for a spine surgeon evaluation and treatment is medically necessary and appropriate.