

Case Number:	CM14-0006842		
Date Assigned:	02/07/2014	Date of Injury:	01/14/2012
Decision Date:	06/11/2014	UR Denial Date:	01/10/2014
Priority:	Standard	Application Received:	01/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine, 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:

This patient is a 45-year-old male with date of injury of 1/14/12. Per the treating physician's report dated 11/18/13, the patient presents with bilateral knee pain, low back pain, and complaints of on-and-off dull pain in the neck with popping and grinding, and pains radiating down into the left shoulder and low back at an intensity of 8-9/10. The patient has constant stabbing pain in the left shoulder at 8/10 in intensity. The patient has a constant throbbing pain at the upper back at 9/10 in intensity. Review of the diagnostic studies shows EMG/NCV studies from 2012 and MRI of the lumbar spine from May 2013. Examination showed 4/5 decreased sensation at the C6 nerve distribution on the left side, normal muscle strength, normal deep tendon reflexes, symmetric measurements of the upper extremities, and weaker left hand grip strength. Listed diagnoses are cervical spine sprain/strain, impingement syndrome, rotator cuff tendinosis, left shoulder, and herniated nucleus pulposus of the lumbar spine with light left-sided radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF LEFT SHOULDER: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: Examination of this patient's shoulder showed positive impingement maneuvers including supraspinatus test, mildly reduced range of motion of the left shoulder, particularly for internal rotation at 20 degrees. For specialized studies, the ACOEM guidelines require the emergence of a red flag, physiologic evidence of tissue insult, or neurovascular dysfunction, failure to progress in strengthening program intended to avoid surgery. In this patient, there is physiologic evidence of tissue insult given persistent pain and positive impingement maneuver. Furthermore, the Official Disability Guidelines support MRI of the shoulder for acute shoulder trauma, suspect rotator cuff impingement over age 40, normal plain radiographs, subacute shoulder pain, and/or suspect instability/labral tear. This patient is over 40 years of age. There is suspicion of rotator cuff impingement syndrome. As such, the request is medically necessary.

MRI OF CERVICAL SPINE: 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): 177-178.

Decision rationale: Examination showed weak left hand grip strength, diminished range of motion of the cervical spine with pain, and some sensory changes in the C6 nerve distribution. In regard to specialized studies, the ACOEM Guidelines require emergence of a red flag, physiologic evidence of tissue insult, and neurologic dysfunction, among other things. In this case, the patient does present with physiologic evidence of tissue insult and neurologic dysfunction, namely radiating symptoms in the upper extremities, sensory deficit, and weak grip strength. These are manifestations of neurologic dysfunction. The patient has failed to improve with conservative care. There is no evidence that the patient has had an MRI of the cervical spine done in the past. As such, the request is not medically necessary.