

<b>Case Number:</b>	CM14-0109902		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	11/14/2013
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 in: Internal 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 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:

The employee was a 37 year old male who sustained an industrial injury on 11/14/2013. He sustained an acute stinger like injury to the neck and right upper extremity while manipulating a heavy axe pick into the ground. Following that he developed increasing pain in neck, shoulder and upper extremity with tingling in the right hand and fingers. The evaluated and treated at an urgent care center with Naproxen and Norco. Subsequent evaluations have included an MRI of C spine, MRI of shoulder, EMG/NCS. His symptoms have included pain in right upper extremity, shoulder, neck and tingling with numbness. His examination findings have included severe tinel with percussion over the right brachial plexus and pectoralis minor region and positive brachial plexus stress test on the right with profound weakness in right upper extremity and allodynia over right upper extremity. He was also noted to have fasciculations of upper extremities. The progress note from 01/15/14 had right upper extremity myelopathy likely secondary to discogenic injury of cervical spine as one of the diagnoses. He was advised to have MRI C spine and shoulder. According to a review on February 28, 2014, employee complained of severe constant neck pain that radiated into the right upper extremity with numbness, tingling, weakness and stiffness in the hands and fingers. He was unable to grip and grasp. The pain was worse in cold weather and pain ranged up to 10/10. The employee complained of symptoms of associated severe depression, anxiety and insomnia. He had no useful function of the right upper extremity. His right arm was braced and protected against use. The right upper extremity did not even have assist function. There was a severe right sided cervical spine tenderness. There was marked restricted range of motion and moderate to severe right scalene and pectoralis minor tenderness on the right. The shoulder range of motion was frozen. Thoracic spine examination revealed that there was severe right perscapular pain and tenderness. As per a review on April 30, 2014, the diagnoses were right shoulder superior labrum tear and right shoulder severe adhesive capsulitis.

On January 15, 2014, MRI had been performed. MRI of the cervical spine revealed mild multilevel degenerative spondylosis, mild central canal stenosis C3-4 and C4-5 and straightening of the cervical lordosis. MRI of the right shoulder revealed mild to moderate rotator cuff tendinosis, mild subacromial/ subdeltoid bursitis and degeneration of the superior labrum with irregularity and fraying. The diagnostic impressions were acute right posttraumatic brachial plexopathy, cervical discogenic injury and rotator cuff tendinosis on right. Nerve conduction study on bilateral median, ulnar nerves and bilateral radial sensory nerves were performed on April 29, 2014. The findings were nerve entrapment neuropathy of bilateral median nerves at wrist, bilateral ulnar nerves at elbows and wrists and no evidence of brachial plexus injury or radiculopathy. The note from 06/04/14 was reviewed. He was complaining of stabbing pain in the neck with radiation to right upper extremity at 9/10. He had right shoulder pain at 9/10 and low back pain at 8/10. He was on Gabapentin and Percocet. Pertinent objective findings included decreased strength with Jamar dynamometer at 0/0/0 L Kgs on right side, decreased DTRs C5, C6 and C7 on right to 1+/2, positive cervical compression test, positive right Hoffman's test, positive Adson's test, loss of muscle strength in the right upper extremity with severe loss of sensation along the C5-C6 nerve distribution on the right, loss of motion of right shoulder, pain on palpation of right shoulder girdle and positive apprehension/Neer's and Hawkin's test. Diagnoses included brachioplexopathy on right, tendonitis of right shoulder with degeneration of superior labrum. The plan of care included a repeat MRI of cervical spine since the previous MRI lacked measurement of the disc bulges at C3-C4 and C5-C6. The report of MRI cervical spine was reviewed from 01/15/14. Osteophytosis was seen from C3-C7, C3-C4 disc desiccation was seen with mild bulging of the posterior annulus, mild central canal narrowing, mild left foraminal stenosis, C4-5 disc desiccation with mild bulging, moderate left foraminal stenosis and mild right foraminal stenosis and disc desiccation with mild bulging of the posterior annulus at C5-C6.

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

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

**MRI Cervical Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): TABLE 8-8, PAGE 179-180.

**Decision rationale:** The employee was a 37 year old male who sustained an injury to his neck, right shoulder and right upper extremity with pain in neck radiating to shoulder. He also had neurological symptoms and signs including numbness, weakness of right upper extremity and loss of sensation of right upper extremity. He had altered deep tendon reflexes. He also had an MRI of cervical spine in January 2014 that showed mild disc bulges and desiccation with mild to moderate foraminal stenosis on left side. His EMG showed no evidence of radiculopathy. His neurological examination had not changed since injury. The request was for a repeat MRI of cervical spine. The treating provider writes that the disc bulges were not measured and hence the need for a repeat MRI. According to MTUS ACOEM guidelines, a repeat MRI is recommended

when there are new neurological findings or if red flag symptoms have developed. The medical records reviewed show that the symptoms and neurological examination are similar to before. The disc bulges were quantified as mild and hence the need for a repeat MRI of C spine is not met according to guidelines. The request for MRI of cervical spine is not medically necessary or appropriate.

