

Case Number:	CM14-0190822		
Date Assigned:	11/24/2014	Date of Injury:	06/01/2012
Decision Date:	03/03/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/15/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Internal Medicine

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 44 year old female worked as a [REDACTED] Clinical Technician when she sustained an injury on June 1, 2012. The injured worker was breaking up an altercation, which resulted in psyche, head, neck, and right shoulder injuries. Past treatment included psychological treatment, postsurgical physical therapy, steroid injection therapy to the shoulder, epidural steroid injection, and medications. Right shoulder surgery for a rotator cuff tear and a SLAP (superior labral tear from anterior to posterior) lesion on July 22, 2013. Currently, the injured worker was being treated with muscle relaxant, pain, anti-epilepsy, and non-steroidal anti-inflammatory/proton pump inhibitor medications. On September 30, 2014, the treating physician noted the injured worker complained of increased, diffuse pain and spasm throughout the right shoulder girdle that persisted since attending the first 3 days of functional restoration program (FRP) earlier in the month. There was an increase of intermittent, diffuse right hand numbness and tingling, and continued sleeping difficulty due to pain in the neck and shoulder. The physical exam revealed forward flexed body posture and elevated right shoulder. The right upper extremity exam revealed soft tissue tenderness over the acromioclavicular joint, muscle tenderness of the pectoralis major, rhomboid, and glenohumeral joint tenderness. The right shoulder range of motion was moderately decreased and motor strength was moderately decreased. The range of motion and motor strength of the right elbow, wrist, and hand were normal. The right shoulder Yergason sign, drop arm sign, Hawkins-Kennedy test, and Apprehension test were positive. Diagnoses included shoulder pain/disorder of the bursa, cervical radiculitis - brachial neuritis or radiculitis, degenerative cervical intervertebral disc, rotator cuff disorder, and

psychophysiological disorder. The physician recommended increasing the pain medication, continuing the muscle relaxant medication, and starting topical pain and topical non-steroidal anti-inflammatory medications. On October 20, 2014, the treating orthopedic physician noted the injured worker was unable to tolerate more than 2 days of a functional restoration program (FRP). Her pain was aggravated by a combination exercise of pulley/shed. Her neck and arm pain increased markedly and she increased her pain medication use to 2 tablets daily. A physical exam was not in the provided visit documentation. The diagnosis was degenerative disc disease of C5-C6 and C6-C7, which failed non-operative measures. The treatment plan included obtaining bone density testing and an updated MRI prior to a discussion regarding surgery for disc arthroplasty. Current work status was not included in the provided medical records. On October 30, 2014, Utilization Review non-certified a prescription for an MRI of the cervical spine without contrast requested on October 28, 2014. The MRI was non-certified based on the lack of documentation of objective findings, radiographs, and any conservative treatment in the clinical summary. The California Medical Treatment Utilization Schedule (MTUS): ACOEM (American College of Occupational and Environmental Medicine), Neck and Upper Back Complaints and Official Disability Guidelines (ODG), Neck and Upper Back (updated 8/402014): Magnetic resonance imaging (MRI) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Magnetic Resonance Imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The orthopedic agreed medical evaluation report dated May 20, 2014 documented MRI magnetic resonance imaging of the cervical spine dated July 24, 2012. The MRI demonstrated mild to moderate cervical spondylosis. No evidence of a focal cervical disc herniation or cervical canal stenosis. No moderate or severe lateral recess stenosis. No cervical myelinolysis. The progress report dated September 30, 2014 did not document physical examination of the cervical spine. The

orthopedic evaluation report dated October 20, 2014 did not document physical examination of the cervical spine. MRI of the cervical spine was requested on October 20, 2014. No physical examination of the cervical spine was documented in the 9/30/14 progress report or the 10/20/14 orthopedic report. Because physical examination of the cervical spine was not documented, the request for MRI of the cervical spine is not supported by the medical records. Therefore, the request for MRI of the cervical spine is not medically necessary.