

Case Number:	CM14-0208280		
Date Assigned:	12/22/2014	Date of Injury:	01/04/2012
Decision Date:	03/12/2015	UR Denial Date:	11/10/2014
Priority:	Standard	Application Received:	12/12/2014

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker (IW) is a 54 year old female who reported injury on 04/06/211 due to, continuous work duties of cleaning hotel rooms, resulted in injury to the neck, bilateral shoulders, bilateral elbows, bilateral hands, back and bilateral knees and feet. The injured worker diagnoses consist of high cholesterol, displacement of cervical intervertebral disc without myelopathy, cervical and thoracic spine radiculopathy, cervical and thoracic spine multilevel degenerative disc disease, bilateral shoulder impingement, bilateral shoulder rotator cuff tears, tenosynovitis, AC joint osteoarthropathy, left elbow sprain/strain, right elbow common extensor tendon tear and lateral epicondylitis, bilateral wrist carpal tunnel syndrome, bilateral wrist subchondral cyst, bilateral knee sprain/strain and medical meniscal tears, right knee chondromalacia patella, right knee arthritis, anxiety disorder, mood disorder, sleep disorder, headaches and abdominal discomfort. Past medical treatments included treatment modalities, physical therapy, electrophysiology, chiropractic care, radiographic imaging, shockwave therapy, heat/cold packs, diagnostic studies and medications. Medications consist of Deprizine, Fanatrex, Tabradol, Synapryn, Dicopanol and Tramadol. Diagnostic studies and radiographic imaging including MRI of the affected areas were performed in April, 2014 revealing the above noted diagnoses. On April 21, 2014, evaluation revealed burning radicular neck pain and ongoing muscle spasms. She described her pain as constant and moderate to severe aggravated by head motion and associated with tingling and numbness of the bilateral upper extremities. Burning pain was also noted in the shoulders, elbows, wrists, mid-upper back, knees and feet. She also complained of associated nervousness, headaches, sleep disturbances and stomach problems. The

treatment plan included shockwave therapy for the cervical spine, physiotherapy of the cervical spine and shoulders, chiropractic care for the cervical spine and shoulders, a pain management consultation for possible steroid injections of the cervical and thoracic spine, an orthopedic consultation for possible right and left shoulder repair and pain patches. Work status is temporarily totally disabled (TTD) from April 21, 2014 through May 19, 2014. On May 19, 2014, evaluation revealed persistent symptoms with temporary relief with medications. The treatment plan remained unchanged. On May 22, 2014 a letter of necessity was issued for the addition of Dicopanол as a sleep and pain relief aide. On June 16, 2014, evaluation revealed persistent symptoms as previously described with some relief with the use of pain medications and restricted activity. The treatment plan remained unchanged. Work status remained unchanged. On July 14, 2014, evaluation revealed no significant improvements. Adjustments were made to pain medications. The recommendation for periodic urinary drug screens was made. On August 11, 2014, evaluation revealed no significant improvement of symptoms. The treatment plan was unchanged. On September 10, 2014, evaluation revealed no changes. The recommendation was for the IW to undergo shock wave therapy for the cervical and thoracic spine and epidural injections of the back. A magnetic resonance image (MRI) was requested by the IW at this time including the shoulders, elbows, wrists, knees, cervical spine and thoracic spine. The documentation noted the IW underwent shockwave therapy treatments with some improvement. Work status is temporary totally disabled (TTD) at this time. On 10/08/2014, the injured worker complained of burning, radicular neck pain and spasm. The pain was described as constant, moderate to severe. The injured worker rated the pain at 8/10. The pain was aggravated by looking up, looking down and side to side as well as repetitive motion of the head and neck. The injured worker also complained of burning bilateral shoulder pain radiating down to the arms into the fingers, associated with muscle spasm. The injured worker rated the pain at 8/10. The physical examination of the cervical spine revealed tenderness to palpation at the occiputs, the trapezius, the levator scapulae, the spinous, and the scalene at the sternocleidomastoid muscles. Range of motion of the cervical spine revealed flexion of 40 degrees, extension of 45 degrees, left rotation of 55 degrees, right rotation of 50 degrees, left lateral flexion of 20 degrees, and right lateral flexion of 25 degrees. Distraction and compression tests were positive. On 04/13/2014, the injured worker underwent an MRI of the cervical spine which revealed grade 1 anterior wedge deformity of C6 vertebra. The rest of the vertebral body heights were maintained. Bone marrow signal was normal. There was no destructive bony lesion. Diameter and signal characteristic of the cervical spinal cord were within normal limits. A rationale was not submitted for review. The Division of Workers' Compensation Request for Authorization for Medical Treatment (RFA) included requests an additional MRI of the cervical spine.

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: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

Decision rationale: The request for an MRI of the cervical spine is not medically necessary. The California MTUS/ACOEM Guidelines indicate that criteria for ordering imaging studies include: An emergence of red flag, physiological evidence of a tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of anatomy prior to invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory testing or bone scans. The submitted documentation did not indicate an emergence of red flag. Additionally, the physical examination of the cervical spine revealed tenderness to palpation, a positive distraction and compression test. Deficits would be congruent with the findings that were found on MRI which was obtained in 04/2014. Furthermore, there was no indication of the patient needing clarification of the anatomy prior to an invasive procedure. Given the above, the request would not be indicated. As such, the request is not medically necessary.