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| <b>Case Number:</b>   | CM15-0160883 |                              |            |
| <b>Date Assigned:</b> | 08/27/2015   | <b>Date of Injury:</b>       | 05/31/2011 |
| <b>Decision Date:</b> | 09/30/2015   | <b>UR Denial Date:</b>       | 07/17/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/17/2015 |

### 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, Indiana, New York  
 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:

The injured worker is a 49 year old female who sustained an industrial injury on May 31, 2015. The worker was employed as an eligibility worker who sustained cumulative trauma over the course of employment with resulting injury. Previous treatment to include: activity modification, couple of therapy sessions, medications, injections. Follow up dated June 25, 2015 reported subjective complaint of left shoulder, left elbow, left wrist and hand and right wrist and hand pains. The impression noted the worker with: cervical spine left disc at C5-6 causing radiculopathy; left shoulder large and aggressive subacromial bone spur causing significant impingement; left elbow medial and lateral epicondylitis from repetitive gripping and grasping; left hand sprain. There is recommendation to obtain an updated magnetic resonance imaging of cervical spine and to begin another course of physical therapy. An initial therapy evaluation dated August 05, 2015 reported the assessment and plan to involve: deficits in pain, mobility, strength, endurance and function. The recommendation is for land therapy to increase functional mobility and strength, provide education and promote independent long-term exercise program in conjunction with short-term skilled therapy.

### 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:** 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): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, MRI cervical spine without contrast is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness with no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy; if severe or progressive neurologic deficit; etc. 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, neurocompression, recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured worker's working diagnoses are cervical spine left-sided disc C-5 - C6 causing radiculopathy; left shoulder large and aggressive subacromial bone spur causing significant impingement; left elbow medial and lateral epicondylitis; and left hand sprain. Date of injury is May 31, 2011. Request authorization is July 10, 2015. According to an initial new patient orthopedic evaluation dated June 24, 2015, the injured worker's subjective complaints are left shoulder pain 8/10, left elbow and wrist and hand pain. There is no documentation of cervical spine subjective complaints. Objectively, the cervical spine shows no pain but spasm is present from C3 - C7. Range of motion is decreased and motor is normal. Sensory is decreased left C5 - C6 (pinwheel). Left shoulder shows stiffness. Range of motion is grossly unremarkable. A radiograph of the left shoulder (undated) shows a large subacromial bone spur. MRI of the cervical spine dated 2011 shows a disc herniation at C5 - C6. The MRI films were not reviewed (MRIs not present in the medical records reviewed by the treating provider). An MRI of the left shoulder dated 2011 showed calcific tendinitis. MRI films were not in the medical record for review by the requesting provider. The requesting provider indicated all medical records were not reviewed. The treating/requesting provider did not have a current list of medications taken by the injured worker. The treating provider requested a urine drug screen to evaluate medication management. There is no documentation indicating aberrant drug-related behavior, drug misuse or abuse. As noted above, there is no documentation of the injured worker is taking opiates or other controlled substances. 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, neurocompression, recurrent disc herniation). There were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Based on the clinical information in the medical record, no clinical subjective symptoms at the cervical spine, no documentation indicating a significant change in symptoms or objective clinical findings suggestive of significant pathology and no unequivocal objective findings that identifies specific nerve compromise, MRI cervical spine without contrast is not medically necessary.

**MRI of left shoulder without contrast: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, MRI.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI left shoulder without contrast is not medically necessary. MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. The indications for magnetic resonance imaging are rated in the Official Disability Guidelines. They include, but are not limited to, acute shoulder trauma, suspect rotator cuff tear / impingement, over the age of 40, normal plain radiographs; subacute shoulder pain, suspect instability/labral tear; repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and or findings suggestive of significant pathology. In this case, the injured worker's working diagnoses are cervical spine left-sided disc C-5 - C6 causing radiculopathy; left shoulder large and aggressive subacromial bone spur causing significant impingement; left elbow medial and lateral epicondylitis; and left hand sprain. Date of injury is May 31, 2011. Request authorization is July 10, 2015. According to an initial new patient orthopedic evaluation dated June 24, 2015, the injured worker's subjective complaints are left shoulder pain 8/10, left elbow and wrist and hand pain. There is no documentation of cervical spine subjective complaints. Objectively, the cervical spine shows no pain but spasm is present from C3 - C7. Range of motion is decreased and motor is normal. Sensory is decreased left C5 - C6 (pinwheel). Left shoulder shows stiffness. Range of motion is grossly unremarkable. A radiograph of the left shoulder (undated) shows a large subacromial bone spur. MRI of the cervical spine dated 2011 shows a disc herniation at C5 - C6. The MRI films were not reviewed (MRIs not present in the medical records reviewed by the treating provider). An MRI of the left shoulder dated 2011 showed calcific tendinitis. MRI films were not in the medical record for review by the requesting provider. The requesting provider indicated all medical records were not reviewed. The treating/requesting provider did not have a current list of medications taken by the injured worker. The treating provider requested a urine drug screen to evaluate medication management. There is no documentation indicating aberrant drug-related behavior, drug misuse or abuse. As noted above, there is no documentation of the injured worker is taking opiates or other controlled substances. 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, neurocompression, recurrent disc herniation). There were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Based on the clinical information in the medical record, no documentation indicating a significant change in shoulder symptoms or objective clinical findings suggestive of significant pathology and no unequivocal objective findings that identifies specific nerve compromise, MRI left shoulder without contrast is not medically necessary.

**Urine Toxicology quantitative and confirmatory testing: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Urine drug screen.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, urine toxicology quantitative and confirmatory testing is not medically necessary. Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances for busy were not can, and uncover diversion of prescribed substances. This test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. The frequency of urine drug testing is determined by whether the injured worker is a low risk, intermediate or high risk for drug misuse or abuse. Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. For patients at low risk of addiction/aberrant drug-related behavior, there is no reason to perform confirmatory testing unless the test inappropriate or there are unexpected results. If required, confirmatory testing should be the questioned drugs only. In this case, the injured worker's working diagnoses are cervical spine left-sided disc C-5 - C6 causing radiculopathy; left shoulder large and aggressive subacromial bone spur causing significant impingement; left elbow medial and lateral epicondylitis; and left hand sprain. Date of injury is May 31, 2011. Request authorization is July 10, 2015. According to an initial new patient orthopedic evaluation dated June 24, 2015, the injured worker's subjective complaints are left shoulder pain 8/10, left elbow and wrist and hand pain. There is no documentation of cervical spine subjective complaints. Objectively, the cervical spine shows no pain but spasm is present from C3 - C7. Range of motion is decreased and motor is normal. Sensory is decreased left C5 - C6 (pinwheel). Left shoulder shows stiffness. Range of motion is grossly unremarkable. A radiograph of the left shoulder (undated) shows a large subacromial bone spur. MRI of the cervical spine dated 2011 shows a disc herniation at C5-C6. The MRI films were not reviewed (MRIs not present in the medical records reviewed by the treating provider). An MRI of the left shoulder dated 2011 showed calcific tendinitis. MRI films were not in the medical record for review by the requesting provider. The requesting provider indicated all medical records were not reviewed. The treating/requesting provider did not have a current list of medications taken by the injured worker. The treating provider requested a urine drug screen to evaluate medication management. There is no documentation indicating aberrant drug-related behavior, drug misuse or abuse. As noted above, there is no documentation of the injured worker is taking opiates or other controlled substances. Based on the clinical information in the medical record, no documentation of aberrant drug-related behavior, drug misuse or abuse, no documentation for the current list of medications including opiates or other controlled substances, urine toxicology quantitative and confirmatory testing is not medically necessary.