MAXIMUS Federal Services

Case Number:	CM15-0202267		
Date Assigned:	10/19/2015	Date of Injury:	05/19/2008
Decision Date:	11/30/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/14/2015

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 71 year old male with an industrial injury date of 05-19-2008, 05-20-2008, continuous trauma 1962-08-21-2004 and 10-05-2004 - 08-19-2008. Medical record review indicates he is being treated for cervicothoracic spine strain with degenerative joint disease and degenerative disc disease with protrusions at cervical 2-cervical 7 and thoracic 1 and thoracic 2, bilateral cervical radiculopathy, right rotator cuff tendinitis - impingement syndrome, left rotator cuff tendinitis-impingement syndrome with full thickness rotator cuff tear and status post left shoulder arthroscopy with arthroscopic rotator cuff repair, subacromial decompression, labral debridement and distal clavicle resection. Subjective complaints (09-10-2015) included flare ups of pain in the cervical spine with attempted increased activity, worsening pain, limitation of motion and clicking in the left shoulder. Work status (09-10-2015) is documented as: "Qualified injured worker." Prior treatment included left shoulder surgery, cervical spine epidurals and medications. Prior diagnostics included MRI of the cervical spine (01-10-2015) documented by the provider in the 02-15-2012 note as showing moderately severe cervical 5-6 central canal stenosis with mild cord compression, severe bilateral neuro foraminal stenosis and at cervical 4-5 there was some progression of moderate central spinal stenosis and worsening of the severe chronic bilateral neural foraminal stenosis. There was no significant change of cervical 3-4, cervical 6-7, cervical 7-thoracic 1 and thoracic 1-thoracic 2 when compared to prior study of 01-29-2010 (summarized). Physical exam (09-10-2015) noted tenderness to palpation over the upper, mid and lower paravertebral muscles. Range of motion was 30 degrees flexion, 30 degrees right lateral bending, 20 degrees left lateral bending, 40

degrees right lateral rotation, 30 degrees left lateral rotation and 20 degrees of extension. There was increased pain with cervical motion. Spurling's, Adson's and Wright's maneuver were negative. Left shoulder exam noted well healed, non-tender arthroscopic incision with no soft tissue swelling or tenderness to palpation. There was a negative impingement sign, grind sign, apprehension sign and relocation sign. There was no shoulder instability and no paresthesia with shoulder motion. Range of motion was 130 degrees flexion, 120 degrees abduction, 45 degrees extension, 45 degrees external rotation, 30 degrees internal rotation and 30 degrees adduction. "There is a greater passive range of motion without obvious adhesive capsulitis." Neurological exam of the upper extremities noted "patchy" decreased sensation in both upper extremities including the median and ulnar nerve distribution with mild depression of the right bicep reflex. There is "patchy" decreased sensation in the bilateral upper extremities most notably in the cervical 6 and median nerve distribution. On 10-02-2015 the request for MRI of the cervical spine and MR arthrogram of the left shoulder was non-certified by utilization review.

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: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back: Magnetic resonance imaging (MRI). (06/25/2015).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, MRI cervical spine 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 cervicothoracic spine strain with degenerative joint disease and disc protrusions from C2 through T2; bilateral cervical radiculopathy; status post right endoscopic carpal tunnel

release; status post left carpal tunnel release and Guymon's canal release with excision of hook of the hamate; left and right rotator cuff tendinitis/impingement syndrome with a full thickness tear on the left; status post left shoulder arthroscopy with rotator cuff repair, subacromial decompression, labral debridement and distal clavicle resection; status post probable right wrist arthroscopy. Date of injury is May 19, 2008. Request for authorization is September 10, 2015. According to the progress note dated September 10, 2015, subjective complaints include flare-ups of cervical spine pain with attempted increased activity with worsening pain and limitation of motion and clicking in the left shoulder. Objectively, there is tenderness to palpation over the upper, mid-and lower paraspinal muscles. Range of motion is decreased. Thoracic spine is tender to palpation. The left shoulder is non-tender. The neurologic examination showed patchy decreased sensation in both upper extremities including the median and ulnar nerve distribution. There is patchy decreased sensation in the bilateral upper extremities most notably in the C6 and median nerve distribution. A cervical spine MRI was performed January 10, 2012. The results showed moderately severe C-5-C6 central spinal stenosis with mild cord compression. Spinal stenosis has slightly progressed from the prior study. There is no significant progression in severe bilateral neuroforaminal stenosis. There is moderate C4-C5 central spinal stenosis. There is slight worsening in the severe chronic bilateral neuroforaminal stenosis. There is no significant change at the C3-C4 and C6-C7 levels where there is mild chronic central spinal stenosis. 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 is no documentation of a significant change in symptoms and/or objective findings suggestive of significant pathology to warrant a repeat cervical MRI. There are no new unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of a significant change in symptoms and/or objective findings to suggest significant pathology and no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation, MRI of the cervical spine is not medically necessary.

MR Arthrogram of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder: MR Arthrogram (9/8/2015).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Arthrography.

Decision rationale: Pursuant to the Official Disability Guidelines, MR arthrogram of the left shoulder is not medically necessary. Arthrography and magnetic resonance imaging have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI more sensitive and less specific. MRI may be the preferred investigation because of its better demonstration of soft tissue anatomy. Subtle tears that are full thickness our best image by arthrography, whereas larger tears and partial thickness tears are best demonstrated by MRI. In this case, the injured worker's working diagnoses are cervicothoracic spine strain with

degenerative joint disease and disc protrusions from C2 through T2; bilateral cervical radiculopathy; status post right endoscopic carpal tunnel release; status post left carpal tunnel release and Guyon's canal release with excision of hook of the hamate; left and right rotator cuff tendinitis/impingement syndrome with a full thickness tear on the left; status post left shoulder arthroscopy with rotator cuff repair, subacromial decompression, labral debridement and distal clavicle resection; status post probable right wrist arthroscopy. Date of injury is May 19, 2008. Request for authorization is September 10, 2015. According to the progress note dated September 10, 2015, subjective complaints include flare-ups of cervical spine pain with attempted increased activity with worsening pain and limitation of motion and clicking in the left shoulder. Objectively, there is tenderness to palpation over the upper, mid-and lower paraspinal muscles. Range of motion is decreased. Thoracic spine is tender to palpation. The left shoulder is non-tender. The neurologic examination showed patchy decreased sensation in both upper extremities including the median and ulnar nerve distribution. There is patchy decreased sensation in the bilateral upper extremities most notably in the C6 and median nerve distribution. A cervical spine MRI was performed January 10, 2012. The results showed moderately severe C-5-C6 central spinal stenosis with mild cord compression. Spinal stenosis has slightly progressed from the prior study. There is no significant progression in severe bilateral neuroforaminal stenosis. There is moderate C4-C5 central spinal stenosis. There is slight worsening in the severe chronic bilateral neuroforaminal stenosis. There is no significant change at the C3-C4 and C6-C7 levels where there is mild chronic central spinal stenosis. There is no documentation in the medical record (subjective symptoms or objective clinical findings) to suggest a recurrent rotator cuff tear or new injury to the left shoulder. As a result, there is no clinical indication or rationale for an MR arthrogram of the left shoulder. Additionally, the injured worker had an ultrasound of the left shoulder January 2012 (post surgery). Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, and no documentation with subjective symptoms or objective clinical findings to suggest a recurrent rotator cuff tear (left shoulder), MR arthrogram of the left shoulder is not medically necessary.