

Case Number:	CM15-0243097		
Date Assigned:	12/18/2015	Date of Injury:	07/26/2006
Decision Date:	01/29/2016	UR Denial Date:	11/24/2015
Priority:	Standard	Application Received:	12/14/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 61 year old female, who sustained an industrial injury on 7-26-2006. The injured worker was diagnosed as having cervical radiculopathy, right shoulder pain, carpal tunnel syndrome-bilateral-status post bilateral release, chronic pain, other, depression, non-steroidal anti-inflammatory drug intolerance, and status post right shoulder surgery. Treatment to date has included diagnostics, right shoulder surgery x2, bilateral carpal tunnel release, cervical epidural steroid injection bilateral C5-6 on 11-13-2014 and 10-20-2015, physical therapy, acupuncture, trigger point injections, and medications. On 11-05-2015, the injured worker complains of neck pain with radiation down the right upper extremity, bilateral shoulder pain, and low back pain. She also reported ongoing, moderate occipital headaches, and insomnia associated with ongoing pain. Pain was rated 8 out of 10 with medications and 10 without (unchanged from 10-01-2015 and 9-10-2015, rated 5 with medication and 8 without on 5-21-2015). Exam of the cervical spine noted spinal vertebral tenderness in C5-7, tenderness to palpation at the bilateral paravertebral C4-7, "moderate to severely limited" range of motion in the cervical spine, sensation intact to the upper extremities, and "decreased" strength on the right. Tenderness to palpation was also noted at the right anterior shoulder. Magnetic resonance imaging of the cervical spine (5-19-2010) was documented as showing mild disc disease at C3-4, with mild right neural foraminal stenosis, and a 2.4mm disc bulge at C6-7, with bilateral neural foraminal stenosis and nerve root impingement. Magnetic resonance imaging of the right shoulder (4-13-2011) was documented as showing large intrasubstance of the supraspinatus tendon and small subdeltoid effusion. She was given a Toradol injection with B12. She was currently not working. Medication use included Lidoderm

patch, Lunesta, Robaxin, Celexa, and Tylenol #4. Magnetic resonance imaging of the cervical spine was requested to further evaluate her persistent pain and symptoms. On 11-24-2015 Utilization Review non-certified a request for magnetic resonance imaging 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 of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Magnetic resonance imaging.

Decision rationale: The claimant has a remote history of a work injury occurring in July 2006. She underwent bilateral carpal tunnel release and right shoulder surgery was done twice. An MRI of the cervical spine in May 2010 showed findings of mild disc disease at C3/4 with mild right foraminal stenosis and disc bulging at C6/7 with bilateral foraminal stenosis and nerve root impingement. An MRI of the right shoulder in April 2011 showed findings of a small subdeltoid effusion and large supraspinatus tendon tear. She underwent bilateral C5/6 epidural injections in November 2014 with a reported 50-80% improvement lasting for two months. On 10/20/15, she underwent a repeat injection. When seen in November 2015 the injection had provided 20-50% improvement. Medications were decreasing pain from 10/10 to 8/10. She reported worsening pain with neck pain radiating down the right upper extremity, low back pain, bilateral shoulder pain, and ongoing moderate occipital headaches. She had insomnia associated with pain. Physical examination findings included appearing in moderate distress. There was vertebral tenderness and bilateral paravertebral tenderness. There was moderately to severely limited cervical spine range of motion due to pain. There was decreased right sided strength. There was right anterior shoulder tenderness. Guidelines recommend against a repeat cervical spine MRI which should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, neurocompression, or recurrent disc herniation. In this case, the claimant has reported increased pain and less pain relief after the recent epidural steroid injection in Oct 2015. However, there are no findings of a progressive neurological deficit. Strength testing is only reported within the past six months without myotomal pattern and the claimant has a history of two prior right shoulder surgeries. There is no new injury and no identified red flags that would indicate the need for a repeat scan. The request is not medically necessary.