

<b>Case Number:</b>	CM14-0115683		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	09/15/2012
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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. The expert reviewer is Board Certified in Neurology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 44-year-old female with a reported date of injury of 9/15/2012. The mechanism of injury is described as pain caused to the right shoulder from overhead lifting and ironing while working in a dry cleaning establishment. The Primary Treating Physician's Progress Reports (PR-2s) submitted for this review indicate that the IW complains of severe shoulder joint pain, stiffness and weakness. Physical exams reveal limited range of motion due to pain with a positive Hawkins and Drop Arm tests on the right, tenderness specific to the acromioclavicular joint and a twitch response noted in the right Trapezius. The diagnosis of record is Rotator Cuff Injury. The IW reports in a Qualified Medical Examination dated 5/2/2014 that a shoulder MRI obtained 8/2013 revealed shoulder tendonitis but the record is not provided for review. The IW's pain complaints have been addressed with recurrent trigger point injections which are reported to provide moderate to significant degree of pain relief. Records indicate that chiropractic and physical therapy treatments have also been obtained. The QME of 5/2/2014 and PR-2s of 7/9/2014 and 8/25/2014 indicate that the IW reports constant low back pain and neck pain which radiates up to the occipital region, in addition to her right shoulder pain complaints. Physical exam findings in these reports note the following with regard to the cervical spine: facet tenderness at C5; tight muscle bands and paravertebral muscle twitch responses on both sides; Spurling's maneuvers on both sides elicits pain without radicular symptoms; range of motion in all planes limited by pain. With regard to the lumbar spine, these reports note the following findings: limited range of motion due to pain; paravertebral muscles on both sides are tender with tight muscle bands and a twitch-response upon palpation which elicited pain; lumbar facet loading is noted to be positive on the right side; and positive straight leg raising on the right and equivocal on the left (negative 5/2/2014, positive 8/25/2014). The neurological sensory and motor examination is otherwise normal without any clinical evidence

for neurological defects. A request for cervical spine and lumbar spine MRIs was submitted on 7/23/2014 and subsequently denied on 7/16/2014. The PR-2 dated 8/25/2014 notes that these studies were obtained on 7/21/2014. The treating physician notes that the MRI of c-spine showed mild degenerative changes at C4-5 with mild spinal canal stenosis; the MRI of lumbar spine showed multilevel degenerative changes and an annular fissure at L4-5 with a small broad-based central disc prolusion. The imaging report itself was not provided for this review; nevertheless, the MRI results are inconsequential for the purposes of this Independent Medical Review -- the purpose of which is to review the original request for the studies which had been denied on 7/16/2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI for the cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178-179 and 303-305.

**Decision rationale:** There is insufficient clinical and physiological evidence provided in the cervical spine and lumbar spine examinations of 5/2/2014, 7/9/2014, and 8/25/2014 to substantiate the medical necessity for MRI studies. With regard to special diagnostic studies for the cervical spine, the MTUS states (Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostics and Treatment Considerations) that the criteria for ordering an imaging study for the neck and/or upper back are: when there is the emergence of a red flag, there is physiologic evidence of tissue insult or neurologic dysfunction, a strengthening program intended to avoid surgery fails to progress, or there is a need to clarify the anatomy before performing an invasive procedure (p. 178 -179). According to MTUS, imaging studies are warranted where there is sufficient, specific and unequivocal evidence of tissue insult or neurological compromise. If the neurological exam is unclear to indicate such, physiological evidence obtained from electromyography (EMG) or nerve conduction (NCV) studies may be ordered to provide specific findings. The cervical spine exams to identify any definitive neurological deficit are absent for this IW; nor have there been any other physiologic diagnostics performed (e.g., electromyography or nerve conduction studies) which would indicate medical necessity for MRI imaging studies. The clinical findings specific to the cervical spine are significant primarily for pain which limits the range of motion, with muscle tenderness, tightness, twitches, and pain-evocation upon palpation. None of the clinical exams (not even the one post-MRI) indicate any physiological evidence of specific neurological compromise. Neither exam findings nor the patient's symptomology indicate the emergence of a red flag or the need for surgery. There has been no documentation that the IW's neck complaints have been addressed with a strengthening treatment plan which has failed to resolve symptoms. The MTUS states the reliance of imaging studies alone to evaluate the source of neck complaints is not recommended as the risk for diagnostic confusion is significant: it is quite possible to obtain findings that have been present before the onset of symptoms which in fact have no association

with the patient's current pain complaints. This is likewise true for lumbar spine imaging studies. According to the MTUS (Chapter 12, Low Back Complaints, Special Studies and Diagnostic and Treatment Considerations, pp. 303 -305), using imaging studies as the sole resource for identifying the source of a patient's low back complaints carries the significant risk of false- positive findings as it is possible that some findings were present prior to symptomology onset and therefore have no clinical or temporal associations with the patient's current complaints. Further, imaging studies of the low back should be reserved for cases where surgery is being considered or where there is need to insignificant to warrant MRI imaging based on that MTUS criteria. Further, the MTUS recommends MRI imaging only when there is unequivocal evidence of specific nerve compromise on a neurological examination and the patient is considering surgical treatment. If the findings are less clear, further evidence, such as that found from electromyography or nerve conduction study should be obtained prior to ordering an imaging study. In this case, there are no specific nor unequivocal physiological findings for neurological deficit which might be responsible for the IW's clinical pain complaints; where physical exams are notable only for pain upon palpation of the paravertebral muscles, some facet tenderness with loading on the right side, and range of motion limited by pain, the neurosensory and motor examinations are normal. A positive straight leg raise exam is insufficient medical evidence to warrant imaging studies where the MTUS states that further physiological evidence of tissue insult or nerve impairment is necessary prior to ordering an MRI. No such studies have been requested or performed. Clearly, surgery is not being considered, as there have been no documented attempts or failures of conservative treatment. According to the MTUS, the lack of unequivocal evidence of neurological compromise found on either the cervical or lumbar spine exams, the absence of additional physiologic studies to identify any specific neural compromise, and the lack of red flags or need for surgery indicates that these MRI studies do not meet MTUS criteria for such and are, therefore, not medically necessary.