

Case Number:	CM14-0142304		
Date Assigned:	09/10/2014	Date of Injury:	06/18/2010
Decision Date:	10/16/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/02/2014

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 Occupational Medicine 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 is a 58 year-old right-hand dominant female who sustained work-related injuries on June 18, 2010. She has history of right carpal tunnel syndrome release in 2007, right thumb trigger release in 2007, left carpal tunnel syndrome release in 2008, left third finger trigger finger release in 2010 at the A-1 pulley, and C5-6 herniated disc and fusion in 2000. Other treatments includes physical therapy, cortisone injections, medications (including opioids, Neurontin), functional capacity evaluation (FCE), urine toxicology screening, The injured worker was initially examined by her provider on June 19, 2010 and she presented continued right shoulder pain down the arm as well as continued pain in both shoulder. On examination, range of motion was limited in all planes, bilaterally. Impingement, Spee, and Yergason tests were positive. On July 8, 2010, her physical therapy sessions were discontinued. She underwent a magnetic resonance imaging (MRI) scan of the bilateral shoulder on July 15, 2010 which revealed (a) marked rotator cuff tendinopathy involving the supraspinatus and anterior infraspinatus segments without tear, (b) marked subscapularis tendinopathy without tear, and (c) prominent lateral acromial downsloping, but no findings of impingement. On March 14, 2011, she underwent a magnetic resonance imaging (MRI) scan of the cervical spine. Results revealed (a) focal kyphosis in the lower cervical spine with slight anterior wedging of C5 and C6 vertebral bodies consistent with old trauma. No central canal stenosis, cord compression, or myelomalacia identified; (b) C5-6 moderate disc degeneration and bilateral uncovertebral hypertrophy with moderate bilateral foraminal narrowing, (c) C6-7 central 1-2mm protrusion without stenosis, and (d) C4-5 moderate facet arthropathy. On August 10, 2011, she underwent a magnetic resonance imaging (MRI) scan of the right shoulder which noted (a) marked rotator cuff tendinopathy with 5-8 millimeter partial thickness bursal surface tear of the distal supraspinatus segment. No full thickness rotator cuff tear or retraction was present; and (b) prominent subscapularis

tendinopathy with small partial thickness distal posterior surface tear suspected. An operative report dated October 18, 2011 notes that she underwent right shoulder arthroscopy with manipulation under anesthesia release of adhesions on glenohumeral joint, subacromial decompression, and distal Mumford procedure arthroscopic. On October 31, 2011, she was recommended to undergo postoperative physical therapy sessions twice a week for six weeks. On January 23, 2012, she reported that she felt much improvement since beginning physical therapy with a new therapist. Her pain has decreased which caused her to take less pain medication however she continued to have pain in the morning and occasionally at night. Only July 3, 2012, she returned to her provider and reported that her prior visit, a cortisone injection was administered but it did not help. She continued to have limited range of motion with pain and has problems doing house work. She also reported a constant ache in her right arm. An electromyography (EMG)/nerve conduction velocity (NCV) studies revealed normal results dated October 8, 2012. There was no evidence of right or left extremity mononeuropathy. On November 6, 2012, she had an Agreed Medical Examination. Per January 13, 2014 records documents that there was no change in the injured worker's symptomatology or intensity. She has lots of pain at night and cannot sleep. She was also severely depressed due to chronic pain and ongoing problems. She has very limited range of motion due to pain. Right shoulder examination noted limited range of motion specifically with abduction and forward flexion but has good internal and external rotation. Neer's test, Hawkin's test, Speed's test and Yergason test were positive. Per January 19, 2014, the injured worker's request regarding physical therapy has been denied. She was very depressed and cannot sleep. On February 4, 2014, she underwent psychological consultation. On February 27, 2014, she then underwent a psychiatric consultation. She was diagnosed with anxiety and depressive disorder not otherwise specified. Per June 24, 2014 records, the injured worker returned to her provider for a follow-up. She reported no change in symptoms but had a recent flare-up due to having to move. A right shoulder examination noted tenderness and continued limitation in range of motion of the shoulders due to pain. Right elbow examination noted tenderness over the lateral epicondyle. Most recent records dated August 5, 2014 documents that the injured worker cannot sleep or lay on either side where she experiences being uncomfortable. She cannot carry her arm and an electrical shock was noted in her shoulder that goes down. Tingling sensation was noted at the on left range of motion. Range of motion was limited. Cervical spine examination noted tenderness over the bilateral cervical muscles. Spurling's test was positive on the left. With left rotation, her increased symptoms were localized to the arm and then went numb. Left shoulder examination noted tenderness over the rotator cuff and acromioclavicular joint. Range of motion was limited due to pain and stiffness. Right shoulder examination noted tenderness over the rotator cuff. Cross chest adduction test was painful. Decreased strength was noted. She is diagnosed with (a) bilateral shoulder impingement, (b) right lateral epicondylitis, and (c) right adhesive capsulitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 217.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic Resonance Imaging (MRI)

Decision rationale: According to evidence-based guidelines, a repeat magnetic resonance imaging (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, it is noted that the injured worker reported of flare-up on June 24, 2014 however she verbalized that there was no change in her symptoms. Physical examination findings do not indicate any significant changes. She continued to experience tenderness and limited range of motion. She is also not being considered for another surgery of the bilateral shoulders. Therefore, the medical necessity of the requested magnetic resonance imaging (MRI) scan of the right shoulder is not established and is non-certified.

MRI OF LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 217.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic Resonance Imaging (MRI)

Decision rationale: According to evidence-based guidelines, a repeat magnetic resonance (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, it is noted that the injured worker reported of flare-up on June 24, 2014 however she verbalized that there was no change in her symptoms. Physical examination findings do not indicate any significant changes. She continued to experience tenderness and limited range of motion. She is also not being considered for another surgery of the bilateral shoulders. Therefore, the medical necessity of the requested magnetic resonance imaging (MRI) scan of the left shoulder is not established and is non-certified.

CT SCAN OF CERVICAL SPINE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Computed Tomography

Decision rationale: Evidence-based guidelines indicate that a computed tomography (CT) scan of the cervical of the spine is indicated for the following: (a) suspected cervical spine trauma, alert, cervical tenderness, paresthesias in hands or feet; (b) suspected cervical spine trauma, unconscious; (c) suspected cervical spine trauma, impaired sensorium (including alcohol and/or drugs); (d) known cervical spine trauma: severe pain, normal plain films, no neurological deficit; (e)) known cervical spine trauma: equivocal or positive plain films, no neurological deficit, and (f)) known cervical spine trauma: equivocal or positive pain films with neurological deficit. In this case, the injured worker has history of prior C5-6 fusion which was performed in 2000. Most recent physical examination findings dated August 5, 2014 indicate that she has tenderness over the bilateral cervical muscles with positive Spurling's test on the left. Range of motion on the left side also caused numbness. Based on this information, it is clear that the injured worker has met the criteria presented above. Therefore, the requested computed tomography (CT) scan of the

cervical spine is medically necessary. Per prior UR determination dated August 20, 2014, it was determined that per guidelines, computed tomography (CT) scan of the neck is recommended for injured workers who have cervical tenderness, has lost consciousness, have impaired sensorium, or to evaluate the status of fusion. There is no sufficient documentation of deficits or problems that would warrant authorization of this imaging study.