

<b>Case Number:</b>	CM14-0147534		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	02/12/2014
<b>Decision Date:</b>	11/14/2014	<b>UR Denial Date:</b>	08/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in pain Medicine and is licensed to practice in Texas & Oklahoma. 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 51-year-old female who reported an injury on 02/12/2014. The injured worker worked at a home health service and worked the night shift for homebound residents. The injured worker stated the injury occurred early in the morning near the end of her shift. She was attempting to place a resident into bed. The injured worker was cradling the resident, trying to swing her into bed. However, at the same time, the resident kicked her feet out and threw her head backwards. She had kicked the injured worker in the right arm. She sustained injuries to her left shoulder blade, neck area, and low back. The injured worker's treatment history included x-ray studies, physical therapy, and medications. The injured worker had an x-ray of the cervical spine on 04/08/2014 that revealed there was loss of normal cervical curvature as seen previously. There was an anterior hypertrophic spurring with degenerative change at C5-6 and C6-7 levels. On 09/20/2014, the injured worker had undergone an MRI of the cervical spine that revealed there was mild reversal of normal cervical lordosis. There was mild to moderate disc space narrowing at C5-6 and C6-7. Vertebral body heights are maintained. The marrow signal throughout the visualized cervical spine was homogeneous without focal abnormality. The craniocervical and cervical medullary junctions were unremarkable. The cervical cord was normal caliber and signal intensity. The injured worker had an MRI of the shoulder on 09/20/2014 that revealed an osseous acromion outlet, the acromion was type 1 and morphology, and coronal images demonstrate moderate lateral down sloping. Mild to moderate AC joint arthrosis was seen with minimal cystic change at the distal clavicular margin. The rotator cuff there was moderate to severe supraspinatus and infraspinatus tendinosis was seen. There was a low grade articular sided partial thickness tear seen on the coronal sequence image 7, partially extending as intrasubstance component more posteriorly. Overall, involvement was less than

50% of the tendon thickness. No full thickness tear or tendon retraction was evident. There was mild reactive subacromial/subdeltoid bursitis. Mild supraspinatus muscle atrophy was identified. At the labra and capsular structures; there was no evidence of Bankart lesion or posterior labral tear. The joint capsule was thickened and hyperintense with evidence of infiltration at the rotator cuff interval, to be correlated with symptoms of adhesive capsulitis. At the biceps tendons and anchor; the long head of biceps tendon was normal anatomic location. There was distention of the biceps tendon sheath. The osseous structure; there was no acute fracture or osteonecrosis. No high grade chondral defects are evident. Other findings; there was suprascapular and spinoglenoid notch appeared normal. The injured worker was evaluated on 08/19/2014, and it was documented the injured worker had persistent neck pain, severe right shoulder pain, and low back pain. The right shoulder pain was most severe. She had completed physical therapy. Physical examination of the cervical thoracic spine and upper extremity revealed the injured worker holds her neck in a normal position. There was no tenderness to direct palpation over the cervical spinous processes. There was tenderness without spasm in the cervical paravertebral muscles, the upper trapezius and the interscapular/dorsal spine region. There was no tenderness or spasm in the right and left medial scapular muscles or sternocleidomastoid muscles. Cervical spine range of motion revealed the injured worker was able to flex the neck to 20 degrees. This maneuver caused increased pain in the neck and the cervical paravertebral muscles. Extension was to 25 degrees with decreased pain in the cervical paravertebral muscles. Right lateral flexion was 10 degrees with increased pain in the cervical paravertebral muscles. Left lateral flexion was to 5 degrees with increased pain, and right rotation was 65 degrees, and left rotation was 60 degrees with increased pain in the cervical paravertebral muscles. Thoracic spine range of motion revealed the injured worker was able to flex the thoracic spine to 50 degrees. This maneuver caused increased pain in the thoracic paravertebral muscles. Right and left lateral flexion was 15 degrees with increased pain in the thoracic paravertebral muscles. Sensation was intact in the upper extremities. Reflexes were 2+ and are equal and reactive in the biceps, triceps, and brachioradialis. Bilateral shoulder examination revealed there was no evidence of heat, swelling, flexion, or synovial thickening or effusion. Contour was symmetrical and there were no gross deformities present. There was no overt muscle atrophy weakness. There were no trophic changes. No pain with palpation of the acromioclavicular joint, subacromial bursa, coracoid process, bicipital groove, or subdeltoid bursa. Impingement sign was negative bilaterally; Hawkin's test was positive on the right and negative on the left. Drop arm test was bilaterally negative. Range of motion of the right shoulder revealed abduction was 145 degrees, flexion was 15 degrees, internal rotation was 30 degrees, external rotation was 90 degrees, and extension was 50 degrees and adduction and was 40 degrees. Diagnoses included cervicothoracic spine myoligamentous sprain/strain, cervical degenerative disc disease, C5-6 and C6-7 lumbar spine myoligamentous sprain/strain, right shoulder impingement syndrome; rule out rotator cuff tear, and left elbow sprain. Medications were not submitted for this review. The request for authorization dated 09/08/2014 was for MRIs for the right shoulder and cervical spine and urine drug screen dated 07/24/2014.

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

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

**MRI of cervical 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 Page(s): 177-179.

**Decision rationale:** The request for Magnetic Resonance Imaging of Cervical Spine is not medically necessary. ACOEM guidelines recommend imaging studies when physiologic evidence identifies specific nerve compromise on the neurologic examination. The provider indicated the injured had physical therapy however, there were no outcome measurements. There is a lack of objective findings identifying specific nerve compromise to warrant the use of imaging. The documentation submitted for review indicated the injured worker had undergone an MRI of the cervical spine on 09/20/2014. As well, the injured worker had undergone an x-ray of the spine on 04/08/2014. The provider failed to indicate the rationale for requesting another MRI of the cervical spine. As such, the request for an MRI of the cervical spine is not medically necessary.

**MRI Of Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209..

**Decision rationale:** The request for Magnetic Resonance Imaging of right shoulder is not medically necessary. ACOEM guidelines recommend imaging studies when physiologic evidence identifies Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems) Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). Imaging studies may be considered for a patient, whose limitations due to consistent symptoms persisted for one month or more, i.e., in cases: When surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear). Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because it demonstrates soft tissue anatomy better. To further evaluate the possibility of potentially serious pathology, such as a tumor. The documentation submitted for review indicated the injured worker had undergone an MRI of the right shoulder on 09/20/2014. The provider failed to indicate the rationale for requesting a second MRI study of the right shoulder. As such, the request for an MRI of the right shoulder is not medically necessary.

**Urine Drug Screen Dated 07/24/14:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment

**Decision rationale:** The request for Urine Drug Screen is not medically necessary. California (MTUS) Chronic Pain Medical Guidelines recommends using a urine drug screen to assess for the use or the presence of illegal drugs. There are steps to take before a therapeutic trial of opioids and ongoing management; opioids, differentiation: dependence and addiction; opioids, screening for risk of addiction (tests); and opioids, steps to avoid misuse/addiction. There was no indication of how long the injured worker has been on opioids. The injured worker had a urine drug screen on 04/08/2014 and on 07/22/2014. The documentation submitted for review, indicated the injured worker date of injury was 02/12/2014; the guidelines recommend a urine drug screen to assess for the presence of illegal drugs and/or dependence and addiction. Per the guidelines, patient at low risk of addiction/aberrant behavior should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless a test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Moreover, the request for urine drug screen dated 07/24/2014 exceeds the recommended amount testing for a urine drug screen per the guidelines. Therefore, the urine drug screen dated 07/24/2014 is not medically necessary.