

<b>Case Number:</b>	CM14-0215609		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	06/11/2014
<b>Decision Date:</b>	03/04/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### **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. 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  
Certification(s)/Specialty: Physical Medicine & Rehabilitation

### **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 patient is a 42-year-old female with a date of injury of 06/11/2014. According to progress report dated 11/12/2014, the patient presents with neck pain, low back pain, and chest pain. The patient rates her pain as 10/10. The pain is characterized as aching, sharp, throbbing pain with weakness. The pain radiates to the right shoulder, right arm, left thigh, right thigh, and down bilateral leg and foot. Examination of the lumbar spine revealed restricted motion with flexion limited to 40 degrees, limited by pain. On palpation, there are paravertebral muscle spasms and tenderness and tight muscle band on both sides. Spinous process tenderness is noted on L4 and L5. Lumbar facet loading is positive on both sides. Straight leg raise testing is positive on the right side at 60 degrees in a sitting position. Examination of the neck revealed restricted range of motion with flexion limited to 20 degrees, extension limited to 30 degrees, left lateral bending limited to 15 degrees, and right lateral bending limited to 15 degrees. There is tenderness noted in the cervical spine, paravertebral muscles, sternoclavicular joint, and trapezius. Muscle tone of trapezius is increased and there is palpable tenderness on the right. Examination of the right shoulder revealed restricted range of motion with flexion limited to 90 degrees and abduction limited to 90 degrees, limited by pain. Hawkins' and Neer's tests are both positive. Cross over and drop arm tests are positive as well. On palpation, there is tenderness in the acromioclavicular joint, coracoid process, glenohumeral joint and greater tubercle of

humerus.

On sensory examination, sensation to pinprick is decreased over the lateral forearm to the right side. The listed diagnoses are: 1. Lumbago. 2. Cervicalgia. 3. Arthropathy, not otherwise specified, of shoulder. 4. Sprain and strain of neck. 5. Thoracic or lumbosacral neuritis or radiculitis. The patient is temporarily totally disabled. The treatment plan was for refill of medications, chiropractic therapy, acupuncture, L5-S1 bilateral lumbar epidural steroid injection, and MRI for the right shoulder. The Utilization Review denied the request on 11/26/2014.

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

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

**Bilateral L5-S1 lumbar epidural steroid injection:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

**Decision rationale:** This patient presents with neck, low back, and right shoulder pain. The current request is for ESI. According to progress report dated 11/12/2014 and Request for Authorization (RFA) dated 11/24/2014, this is a request for lumbar epidural steroid injection at level L5-S1. The MTUS Guidelines has the following regarding ESI under its chronic pain section page 46 and 47, "recommended as an option for treatment for radicular pain defined as pain in the dermatomal distribution with corroborated findings of radiculopathy." It does not appear that this patient has trialed epidural steroid injections in the past. The patient presents with continued low back pain that radiates into the lower extremity down bilateral legs. MRI of the lumbar spine dated 09/10/2014 revealed at level L5-S1 "focal central disk protrusion measuring 10 mm in transverse and 5 mm in AP dimension." In this case, given the patient's radicular symptoms and significant herniation at L5/S1 the requested ESI IS medically necessary.

**MRI of the right shoulder:** 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), Shoulder Chapter, MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation shoulder chapter, MRI

**Decision rationale:** This patient presents with neck, low back, and right shoulder pain. The current request is for MRI. According to progress report dated 11/12/2014 and Request for Authorization (RFA) dated 11/24/2014, this is a request for MRI studies for the right shoulder. The treating physician states that an MRI is required in order "to rule out any structural pathology that might require surgery and to establish further recommendations regarding patient's treatment plan." ACOEM Guidelines has the following regarding shoulder MRI on pages 207 and 208, routine testing (laboratory test, plain-film radiographs of the shoulder) and

more specialized imaging studies are not recommended during the first 6 weeks of activity

limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of serious shoulder condition or referred pain. The ODG Guidelines under the shoulder chapter supports MRI of the shoulder if conservative measures have failed and rotator cuff/labral tear are suspected. Review of the medical file indicates the patient had an MRI of the right shoulder on 09/12/2014 which showed downsloping of the acromion which may cause subacromial impingement, subtle subacromion bursitis with no rotator cuff tendinopathy, and developing SLAP lesion versus fraying of the posterosuperior labrum. In this case, there are no new injuries, no significant changes in examination, or new location of symptoms requiring additional investigation. The requested repeat MRI of the right shoulder IS NOT medically necessary.