

<b>Case Number:</b>	CM15-0110619		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	07/26/2008
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 30 year old female, who sustained an industrial injury on 7/26/2008. Diagnoses include shoulder pain. Treatment to date has included diagnostics, surgical intervention (arthroscopic rotator cuff repair 8/22/2011), medications including [REDACTED] natural pain relieve gel, injections, acupuncture and a TENS unit. Magnetic resonance imaging (MRI) of the cervical spine dated 6/09/2014 was read by the evaluating provider as showing a 1mm broad based disc bulge causing mass effect on the anterior thecal sac causing minimal spinal canal stenosis and no neural foraminal stenosis with minimal degenerative disease of the cervical spine and minimal canal stenosis. EMG (electromyography)/NCV (nerve conduction studies) of the upper extremities dated 5/29/2013 revealed an abnormal electrodiagnostic study. There is electrodiagnostic evidence of left moderate distal medial nerve neuropathy at the wrist (carpal tunnel syndrome) without active denervation. There was no electrodiagnostic evidence of left cervical radiculopathy, left brachial plexopathy or distal upper extremity mononeuropathy. Per the Primary Treating Physician's Progress Report dated 5/01/2015, the injured worker reported neck pain and left shoulder pain, described as unchanged since the last visit. She rated her pain as 7/10 without medications. Physical examination of the cervical spine revealed restricted range of motion in all planes. There was hypertonicity, spasm, tenderness, tight muscle band and trigger point noted on both sides of the paravertebral muscles. There was tenderness at the paracervicals, rhomboids and trapezius. Examination of the left shoulder revealed restricted movements upon extension and abduction with normal flexion. Neer test was positive. There was tenderness upon palpation of the acromioclavicular joint and sub deltoid bursa. The plan of care

included diagnostic imaging and authorization was requested for MRI of the cervical spine and left shoulder.

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

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

**MRI (magnetic resonance imaging) of the Cervical Spine, without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

**Decision rationale:** Pursuant to the ACOEM and the Official Disability Guidelines, MRI cervical spine without contrast is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness with no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the injured worker's working diagnoses are shoulder pain. Subjectively, according to a May 1, 2015 progress note (request for authorization date same day), the injured worker has ongoing neck pain. The documentation indicates the injured worker had an MRI June 9, 2014. MRI results showed a 1 mm broad-based disc causing mass effect on the anterior sac causing minimal spinal cord stenosis at C6 - C7. There is no neural foraminal stenosis. There is minimal degenerative disc disease. The injured worker is working full-time. The injured worker has stopped all medications. Objectively, there is tenderness palpation over the paracervical muscles, rhomboids and trapezius. There is hypertonicity, spasm and trigger points noted on physical examination. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). There is no clinical rationale in the medical record for repeating the MRI cervical spine. There are no new significant symptoms and/or clinical findings suggestive of significant pathology. There are no unequivocal objective findings and identify specific nerve compromise. Consequently, absent clinical documentation

with significant new symptoms and/or clinical findings suggestive of significant pathology, an MRI performed June 9, 2014 and no unequivocal objective findings that identify specific nerve compromise, (repeat) MRI cervical spine without contrast is not medically necessary.