

Case Number:	CM13-0002090		
Date Assigned:	03/03/2014	Date of Injury:	08/29/2010
Decision Date:	04/11/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/18/2013

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 Orthopedic Surgery 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 patient is a 50-year-old male farm worker who sustained an industrial injury on 8/29/10 when his left foot got stuck in gopher hole, while moving approximately 50 pounds of tomatoes. He fell backwards and to the left. He complained of back, left knee and left ankle pain. Past medical history was positive for left shoulder rotator cuff repair and clavicle resection. The 2/18/11 left ankle MRI revealed moderate osteoarthritis of all facets at the subtalar joint, mild osteoarthritis at the talonavicular joint, mild peroneal synovitis, and small ganglion at the talocalcaneal ligament. The patient was diagnosed with traumatic tarsal tunnel syndrome with possible ganglion cyst involvement. The 4/8/11 bilateral lower extremity EMG/NCV findings showed no evidence of peripheral nerve entrapment or polyneuropathy. The patient underwent two ankle cortisone injections to the ankle that produced 5 % pain relief for two hours following the injection. Custom foot orthotics were provided, without improvement. He reported a subsequent onset of cervicothoracic pain extending into the left shoulder and radiating into the left arm, while walking without his 'Moon boot'. The 9/25/12 neck x-rays showed degenerative changes of the cervical spine with no evidence of osseous abnormality. The 9/4/12 bilateral upper and lower extremity EMG/NCV findings showed no evidence of peripheral neuropathy, cervical or lumbosacral radiculopathy, or brachial or lumbosacral plexopathy. The 5/18/13 treating physician report cited subjective complaints of cervical, left ankle, and low back pain. Exam findings documented left ankle tenderness and stiffness on motion with radiating lateral leg pain extending to the low back. Cervical tenderness and stiffness was reported with radiating diffuse upper extremity dysesthesias, left greater than right. Compression testing was negative. The diagnosis was lumbar sprain/strain, lumbar discogenic pain, lumbar facet syndrome, lumbosacral radiculopathy, ischial bursitis, piriformis syndrome, hip pain, hip capsulitis, ankle sprain, ankle pain, and chronic pain. The treatment plan recommended a cervical MRI to

evaluate problems and an ankle injection as previous injections helped with symptoms. The 10/18/13 treating physician report recommended cervical spine MRI to look for space-occupying lesions or other problems that could be causing the persistent pain, numbness and weakness into the left upper extremity that have persisted despite conservative therapies. Subjective complaints included continued sharp shooting pains from the neck into the upper extremity, left more than right, with persistent numbness and weakness. Cervical spine exam findings documented restricted flexion/extension, muscle tenderness, upper extremity abduction/elevation produced left shoulder pain radiating into the arm, gross hand intrinsic and left upper extremity weakness, and asymmetric first sensation in C7.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI SPINAL CANAL CERVICAL; WITHOUT CONTRAST: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 177-178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck And Upper Back, Magnetic Resonance Imaging (MRI).

Decision rationale: The California MTUS do not provide recommendations for cervical imaging in chronic injuries. The Official Disability Guidelines (ODG) indicate that MRI imaging is valuable when physiologic evidence indicates tissue insult or nerve impairment or potentially serious conditions. ODG Guidelines recommend MRI for patients with chronic neck pain after 3 months of conservative treatment when radiographs are normal and neurologic signs or symptoms are present. ODG Guideline criteria were met. The patient presents with complaints of neck and upper extremity pain with plausible sensory and motor clinical findings of neurocompression (despite electrical findings.) X-rays documented degenerative changes of the cervical spine. The request for a MRI of the cervical spine without contrast, is medically necessary and appropriate.

LEFT ANKLE INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle And Foot, Injections (Corticosteroid)

Decision rationale: The California MTUS do not provide recommendations for treatment of chronic ankle injuries. The Official Disability Guidelines do not recommend ankle corticosteroid injections for tendonitis or intra-articular use. MRI findings documented mild to moderate ankle osteoarthritis and the patient has been diagnosed with an ankle sprain. Left ankle

injections were documented in 2011 with 5% pain reduction lasting two hours. The request for a left ankle injection is not medically necessary and appropriate.