

Case Number:	CM13-0043870		
Date Assigned:	12/27/2013	Date of Injury:	02/23/2007
Decision Date:	03/06/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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 34 year old female who reported an injury on 02/23/2007 after she assisted a patient with a transfer that reportedly caused injury to her neck, back and right shoulder. The patient's treatment history included multiple medications, Toradol injections, activity modification, orthotic inserts, and physical therapy. The patient underwent an MRI of the cervical spine in 04/2012 which identified multilevel disc protrusions and multilevel spondylosis. The patient's most recent clinical examination included documentation of a restricted cervical spine with tenderness and spasm to the upper trapezius musculature bilaterally. The patient's diagnoses included herniated cervical disc with radiculopathy, right shoulder impingement syndrome with tendonitis, facet joint hypertrophy of the lumbar spine, symptoms of anxiety and depression, and symptoms of insomnia. The patient's treatment plan included MRIs of the cervical spine, lumbar spine, and a right shoulder arthrogram. Electrodiagnostic studies, a home exercise kit, continuation of medications, and a cervical pillow were also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical Magnetic Resonance Imaging (MRI): 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),TWC, Acute & Chronic Lumbar and Thoracic Spine Complaints; MRI's.

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 and Upper Back Chapter, MRI

Decision rationale: The requested cervical magnetic resonance imaging is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously underwent a cervical MRI. The American College of Occupational and Environmental Medicine recommend imaging studies when there is evidence of neurological deficits that require further imaging to establish pathology. The clinical documentation submitted for review does not provide any evidence of any recent neurological deficits that would require an imaging study. Additionally, Official Disability Guidelines do not recommend repeat imaging unless there is a significant change in the patient's clinical presentation to support progressive neurological deficits and a change in pathology. The clinical documentation submitted for review does not provide any evidence that the patient has a significant change in pathology or a significant progression of neurological deficits. Therefore, the cervical magnetic resonance imaging (MRI) is not medically necessary or appropriate.

Lumbar Magnetic Resonance Imaging MRI: 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),TWC, Acute & Chronic Lumbar and Thoracic Spine Complaints; MRI's.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested lumbar magnetic resonance imaging (MRI), is not medically necessary or appropriate. The most recent clinical evaluation submitted for review does not provide any deficits or evaluation regarding the lumbar spine. The American College of Occupational and Environmental Medicine recommend an imaging study to clarify neurological deficits revealed during physical examination. As a recent assessment of the lumbar spine was not provided for review, the need for a lumbar imaging study cannot be determined. As such, the requested lumbar magnetic resonance imaging (MRI) is not medically necessary or appropriate.

Right Shoulder Magnetic Resonance Imaging (MRI): 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),TWC, Acute & Chronic Shoulder Complaints; MRI's

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

Decision rationale: The requested right shoulder magnetic resonance imaging is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend shoulder imaging when surgery is being considered for patients with shoulder

limitations and documentation of physical findings consistent with those limitations in order to evaluate possible red flag conditions. The clinical documentation submitted for review does not provide a recent evaluation of the patient's shoulder to support significant deficits that would require surgical intervention or provide suspicion of red flag diagnoses. Therefore, the need for an MRI is not indicated. As such, the requested right shoulder magnetic resonance imaging (MRI) is not medically necessary or appropriate.

Home Exercise Kit, Optimum Home Rehab Kit Lumbar Spine: 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),TWC, Acute & Chronic Neck & Upper Back Complaints

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

Decision rationale: The requested home exercise kit, optimum home rehab kit for the lumbar spine is not medically necessary or appropriate. California Medical Treatment Utilization Schedule states "there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." However, the clinical documentation submitted for review does not provide any recent evidence of lumbar deficits that would support the need for a home exercise program. Additionally, there is no documentation of how a home exercise program would benefit from the addition of exercise equipment. Therefore, the decision for home exercise kit, optimum home rehab kit lumbar spine is not medically necessary or appropriate.