

<b>Case Number:</b>	CM13-0048688		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/03/2001
<b>Decision Date:</b>	02/26/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### 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 61-year-old female who reported an injury on 07/03/2001, due to a slip and fall that caused injury to the low back and cervical spine. The patient's treatment history included medications, physical therapy, a TENS unit, and a functional restoration program. The patient underwent a cervical MRI in 02/2011 that concluded there was degenerative disc disease and multilevel disc herniations that caused encroachment upon the central canal and cervical spinal cord. The patient ultimately developed chronic cervical pain and was treated with acupuncture, epidural steroid injections, psychiatric support, and physical therapy. The patient underwent an electrodiagnostic study in 10/2013 that revealed there was no evidence of right cervical radiculopathy; however, there was significant evidence of peripheral neuropathy. The patient's most recent clinical evaluation revealed restricted cervical range of motion secondary to pain, hyperesthesia to light touch in the bilateral upper and lower extremities, and a positive shoulder apprehension test and Hawkins' test. The patient's diagnoses included cervical radiculopathy and rotator cuff syndrome with bursitis. The patient's treatment plan included a cervical MRI, continuation of medications, a functional capacity evaluation prior to participation in a functional restoration program, and psychiatric consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Cervical Spine without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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 Chapter, MRI.

**Decision rationale:** The requested MRI of Cervical Spine without contrast (72141) is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient previously received a cervical MRI. Official Disability Guidelines do not recommend repeat imaging unless there is a significant change in the patient's clinical presentation that would provide suspicion of progressive neurological deficits or a change in pathology. The clinical documentation submitted for review does not provide any evidence that the patient has had significant progressive neurological deficits since the last MRI. Additionally, there is no documentation that the patient has had a significant change in pathology to support an additional imaging study. As such, the requested MRI of Cervical Spine without contrast (72141) is not medically necessary or appropriate.

**Functional Restoration Program for Evaluation with a MPN Doctor:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30.

**Decision rationale:** The requested Functional Restoration Program for Evaluation with a MPN Doctor is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient previously participated in a functional restoration program. Official Disability Guidelines state that "neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury." The clinical documentation submitted for review does support that the patient previously participated in a functional restoration program. Therefore, enrollment in an additional functional restoration program would not be indicated for this patient. Additionally, functional restoration programs are not recommended for patients who have injuries older than 24 months. The patient's injuries exceed this recommended duration. As such, the requested Functional Restoration Program for Evaluation with a MPN Doctor is not medically necessary or appropriate.

**Functional Capacity Evaluations for baseline testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Dnd ed. Chapt7, page 137.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30.

**Decision rationale:** The requested Functional Capacity Evaluations for baseline testing is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend functional capacity evaluations for baseline testing prior to entry of a multidisciplinary program. However, the clinical documentation indicates that the patient previously participated in a functional restoration program. Therefore, additional enrollment would not be indicated. Therefore, a functional capacity evaluation for baseline testing would also not be indicated. As such, the requested Functional Capacity Evaluations for baseline testing is not medically necessary or appropriate.

**Psychiatric Consultation for initial evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupation Medicine Practice Guidelines, 2nd edition, 2004 Chapter 7, page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (functional restoration programs) and Psychological evaluations Page(s): 30,100.

**Decision rationale:** The requested Psychiatric Consultation for initial evaluation (90885) is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend psychiatric support for patients with chronic pain. However, the clinical documentation submitted for review does provide evidence that the patient was already evaluated for the need for psychiatric support and was receiving treatment. Therefore, the need for an additional psychiatric consultation is not indicated. As such, the requested Psychiatric Consultation for initial evaluation (90885) is not medically necessary or appropriate.