

Case Number:	CM14-0104829		
Date Assigned:	07/30/2014	Date of Injury:	05/12/2011
Decision Date:	10/14/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/08/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Colorado. 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 injured worker is a 52 year old female teacher who sustained an injury on May 12, 2011 when she was trying to keep a student from falling and was pulled against the wall striking her right shoulder resulting in shoulder pain down to right elbow. A second injury occurred on April 11, 2013 when she fell off a stool hitting her neck against a table falling onto her right side resulting in neck, right elbow, and low back pain. She has undergone conservative treatment, chiropractic x 6 with benefit, injections with temporary relief. She underwent right shoulder rotator cuff tear repair in 2012. A magnetic resonance imaging scan showed full thickness tear. On August 20, 2013, a magnetic resonance imaging scan of the lumbar spine showed bulging at L3/4, L4/5, L5/S1 with moderate to severe narrowing. An August 20, 2013 magnetic resonance imaging scan of the cervical spine showed multi-level spondylosis with narrowing. A May 22, 2014 office visit notes electromyogram results of upper extremity showing bilateral moderate compression of median nerve at carpal tunnel with no other neuropathic or radicular findings. An electromyogram of the lower extremities was normal. Exam notes C spine flexion 50, extension 10, 10 lateral bend, rotation to right 20, left 10, marked weakness of right arm with abduction and flexion, 5/5 motor; lumbar spine flexion 20, extension 30, normal gait, bilateral positive straight leg raises, normal sensory, normal motor. Diagnosis is cervical sprain with herniated C6/7 with radicular symptoms, lumbar spine herniation L3-4, L5-S1 with radicular symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL INJECTION AT L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural steroid injections (ESIs), therapeutic

Decision rationale: This is a 3 year old injury and there are no indication that the purpose of this injection is to facilitate and active treatment program and there is no indication that conservative treatment measures have been attempted and failed. The medical treatment guidelines note that the purpose of epidural injections are to facilitate progress in an active treatment program (exercise based) and that treatment alone offers no long-term functional benefit. Thus, in that conservative treatment is not noted, and in that this is being requested as a stand alone treatment without an active treatment program, the criteria of the guidelines have not been met and the requested treatment is not medically necessary. This injured worker has a 3-year-old injury with no significant changes in the injured worker's condition. The clinical findings reported do not support use of an epidural injection as sensory and motor findings are normal with no neural tension signs noted. Epidural injections are typically utilized during the acute-to-subacute phase of injury. They are not curative in nature and are temporary measures for pain relief. The information provided does not reflect use of epidural injections previously or level of success if utilized .Therefore, the request is not considered medically necessary.

MRI OF LUMBAR SPINE; CERVICAL 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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177; 303.

Decision rationale: This is a 3 year old injury with documentation of a new injury, there are no red flags or progressive neurological changes documented. Thus, the request does not meet the criteria of the medical treatment guidelines. The medical treatment guidelines note that a magnetic resonance imaging scan evaluation is supported with a history of trauma, progressive neurological changes, and presence of red flags. This criterion is not present. Therefore the requested magnetic resonance imaging of the lumbar & cervical spine is non certified.

ADDITIONAL 6 SESSIONS OF CHIRO TO NECK AND LOW BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Manipulation

Decision rationale: The medical treatment guidelines require documentation of pain and functional improvement for approval of additional therapy. While the attending provider notes improvement, there is no quantification per visual analog scale scoring and no documentation of functional improvement. Thus, the request does not meet the criteria of the medical treatment guidelines. Based on the documents provided and per the guidelines the requested additional 6 sessions of chiropractic treatment to the neck and low back is non certified.

MRI OF RIGHT SHOULDER WITH INTRAARTICULAR CONTRAST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: Per the guidelines, "For most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out." This injured worker has a 3-year-old injury with no interim trauma. There is no indication of conservative measures and there are no red flags to establish the medical necessity of the magnetic resonance imaging scan. Therefore, the requested magnetic resonance imaging of the right shoulder with intraarticular contrast is not considered medically necessary.