Case Number:	CM14-0077176		
Date Assigned:	07/21/2014	**Date of Injury:**	05/14/2013
Decision Date:	09/17/2014	**UR Denial Date:**	05/08/2014
Priority:	Standard	**Application Received:**	05/27/2014

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 Emergency Medicine and is licensed to practice in New York. 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 41-year-old female who was injured on May 14, 2013. The patient continued to experience pain in her bilateral shoulders, wrist, cervical spine, and lumbar spine. Physical examination was notable for pain on elevation for the upper extremities bilaterally, decreased grip strength bilaterally, and spasm/tenderness in the paravertebral muscles of the cervical and lumbar spines. Diagnoses included cervical radiculopathy, lumbar radiculopathy, shoulder tendonitis/bursitis, wrist tendonitis/buritis and hand sprain/strain. Treatment included medications, and physical therapy. Requests for authorization for MRI of the lumbar spine and cervical spine, functional capacity evaluation, and 12 sessions of physical therapy to cervical spine, lumbar spine, right shoulder, right wrist, and right hand were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging of the lumbar and cervical spine.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 50.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar and Thoracic MRI's (Magnetic resonance imaging); Neck and Upper Back, Magnetic resonance imaging (MRI).

Decision rationale: Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Per ODG indications for MRI of the cervical spine are: -Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit- Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present- Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present- Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"- Known cervical spine trauma: equivocal or positive plain films with neurological deficit- Upper back/thoracic spine trauma with neurological deficit MRI of the spine is recommended for indications below. MRI's are test of choice for patients with prior back surgery. MRI of the lumbar spine for uncomplicated low back pain, with radiculopathy, is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, and recurrent disc herniation).Indications for imaging -- Magnetic resonance imaging:- Thoracic spine trauma: with neurological deficit- Lumbar spine trauma: trauma, neurological deficit- Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit)- Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"- Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit.- Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome- Myelopathy (neurological deficit related to the spinal cord), traumatic- Myelopathy, painful- Myelopathy, sudden onset- Myelopathy, stepwise progressive- Myelopathy, slowly progressive- Myelopathy, infectious disease patient- Myelopathy, oncology patientIn this case there is no documentation of the appearance of red flags or change in the patient's neurologic exam. There is no documentation of prior imaging studies. Therefore, the request is not medically necessary.

FCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines for FCE.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty: Functional Capacity Evaluations.

Decision rationale: Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and

multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants.Consider an FCE if; Case management is hampered by complex issues such as:- Prior unsuccessful RTW attempts.- Conflicting medical reporting on precautions and/or fitness for modified job.- Injuries that require detailed exploration of a worker's abilities.2. Timing is appropriate:- Close or at MMI/all key medical reports secured.- Additional/secondary conditions clarified.Do not proceed with an FCE if- The sole purpose is to determine a worker's effort or compliance.- The worker has returned to work and an ergonomic assessment has not been arranged.IN this case there is no documentation that the patient has failed attempts at return to work. There is also no documentation that the case is close to Maximal medical improvement. Additional testing has been requested. Conditions for FCE have not been met. Therefore, the request is not medically necessary.

12 sessions of physical therapy, to the cervical, lumbar, right shoulder, right hand, and right wrist.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks;and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the number of visits requested surpasses the number recommended for trial. There is mention that the patient had prior approval for physical therapy. There is no documentation of objective evidence of functional improvement. In addition the goal of the therapy is not clear due to requested physical therapy for multiple anatomical areas. Therefore, the request is not medically necessary.