

Case Number:	CM14-0093123		
Date Assigned:	07/25/2014	Date of Injury:	10/01/2013
Decision Date:	09/09/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/19/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review, indicate that this 33-year-old female was reportedly injured on October 1, 2013. The mechanism of injury was noted as a repetitive syndrome. The most recent chiropractic assessment, dated May 27, 2014, indicated that there were ongoing complaints of cervical spine pain, thoracic spine pain, lumbar spine pain, bilateral shoulder pain, right wrist and right thumb pain. The physical examination demonstrated a 5 foot, 170 pound individual in no acute distress. There was reported tenderness to palpation of the cervical, thoracic and lumbar spine. No specific neurological findings were reported. Diagnostic imaging studies were not reviewed. Previous treatment included comprehensive orthopedic surgeon assessment, physical therapy, multiple medications and conservative care. A request was made for an MRI of the cervical spine and lumbar spine and was not certified in the pre-authorization process on June 4, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): electronically sited.

Decision rationale: When noting the date of injury, the comprehensive clinical evaluation completed shortly after the date of injury, the current complaints, and the physical examination reported by the requesting provider, there is no clinical indication to suggest the need of a MRI of the cervical spine. There was no progressive neurological deficit identified and the diagnosis offered was a simple sprain/strain of the cervical spine. Furthermore, there were no findings on physical examination that would support any of the criteria required by the ACOEM guidelines. Therefore, based on the clinical information presented for review, this request for an MRI of the cervical spine is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: When noting the date of injury, the comprehensive clinical evaluation completed shortly after the date of injury, the current complaints, and the physical examination reported by the requesting provider, there is no clinical indication to suggest the need of a MRI of the lumbar spine. There was no progressive neurological deficit identified and the diagnosis offered was a simple sprain/strain of the lumbar spine. Furthermore, there were no findings on physical examination that would support any of the criteria required by the ACOEM guidelines. Therefore, based on the clinical information presented for review, this request for an MRI of the lumbar spine is not medically necessary.

Shockwave therapy for spine 1-2/wk x6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder, updated July 2014.

Decision rationale: It is noted that this intervention is not addressed in the MTUS or ACOEM guidelines. The parameters noted in the ODG were used. This is recommended for calcifying tendinitis alone and that diagnosis has not been objectified in this particular situation. Therefore, based on the chiropractic assessment and by the parameters noted in the ODG, there is no clinical indication for this intervention. The medical necessity has not been objectified in the progress notes presented. Therefore, the request for shockwave therapy for spine 1-2/wk X 6 is not medically necessary.