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| Case Number: | CM14-0207233 | | |
| Date Assigned: | 12/19/2014 | Date of Injury: | 09/17/2006 |
| Decision Date: | 02/19/2015 | UR Denial Date: | 11/23/2014 |
| Priority: | Standard | Application Received: | 12/10/2014 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

47y/o female injured worker with date of injury 9/17/06 with related bilateral shoulder pain. Per progress report dated 10/23/14, the injured worker complained of continued pain in the bilateral shoulders, which she rated 8/10 in intensity. The pain radiated to the bilateral arms with burning and throbbing sensation. She also complained of neck, upper back, low back, and bilateral hip pain. Per physical exam of the cervical spine, there was restricted and painful range of motion. There was paraspinal tenderness with paraspinal spasms; positive foraminal compression test and positive Spurling's test. Per exam of the lumbar spine, there was tenderness to palpation in the paraspinal musculature with positive straight leg raise test bilaterally. There was hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature noted at L5-S1 dermatome distribution. There was weakness in the big toe dorsiflexor and big toe plantar flexor bilaterally. EMG/NCV tests of the bilateral upper extremities demonstrated bilateral carpal tunnel syndrome as well as cubital tunnel syndrome on the left. The documentation submitted for review did not state whether physical therapy was utilized. Treatment to date has included neuroplasty and decompression C3-C6, therapeutic facet blocks, cervical radiofrequency ablation, and medication management. The date of UR decision was 11/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the 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)

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

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, 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. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted for review did not contain evidence of any new red flag neurologic findings on physical examination. It is indicated that prior MRI of the lumbar spine has been performed (undated). It revealed a disc bulge at L5-S1 with some stenosis. This request is not medically necessary.