

Case Number:	CM15-0160561		
Date Assigned:	08/26/2015	Date of Injury:	03/31/2010
Decision Date:	09/30/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	08/17/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 73-year-old female who sustained an industrial injury on 3-31-10. Diagnoses are right shoulder adhesive capsulitis, right shoulder residuals after prior arthroscopic surgical procedure, which appears to have been subacromial decompression and distal clavicle resection, cervical strain, cervical degenerative disc disease, and cervical disc herniations. In a progress report dated 5-20-15, the primary treating physician notes continued complaints of constant to moderate severe neck pain radiating to the right shoulder and constant moderate to severe right shoulder pain with stiffness radiating to the right upper extremity. Examination reveals severely diminished range of cervical motion with pain, tender trapezius muscles and cervical paraspinals. The right shoulder exam reveals a positive Speed's, positive impingement, and positive drop arm. Previous treatment noted includes physical therapy, right shoulder surgery, home stretching program, and medication. Work status is to remain off work. The requested treatment is outpatient MRI-cervical. The patient had received an unspecified number of PT visits for this injury. The patient has had a history of gunshot wound to his stomach, fracture of tibia and surgery. The patient sustained the injury when a horse hit him. Per the note dated 7/29/15, the patient had complaints of leg pain at 8/10. A recent detailed physical examination of the cervical region was not specified in the records specified. Any diagnostic imaging report was not specified in the records provided

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient MRI Cervical: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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) Neck & Upper Back (updated 06/25/15) Magnetic resonance imaging (MRI).

Decision rationale: Per the ACOEM chapter 8 guidelines cited below "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out". Per the ACOEM chapter 8 guidelines cited below recommend "MRI or CT to evaluate red-flag diagnoses as above, MRI or CT to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. If no improvement after 1 month bone scans if tumor or infection possible, not recommended: Imaging before 4 to 6 weeks in absence of red flags". A recent detailed physical examination of the cervical region was not specified in the records provided. A detailed neurological exam of the upper extremities documenting significant neurodeficits was not specified in the records provided. Patient does not have severe or progressive neurological deficits that are specified in the records provided. The findings suggestive of tumor, infection, fracture, neuro-compression, or other red flags were not specified in the records provided. A report of a recent cervical spine plain radiograph was also not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Previous PT notes were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A plan for an invasive procedure of the cervical spine was not specified in the records provided. The request for Outpatient MRI Cervical is not medically necessary or fully established for this patient.