

Case Number:	CM15-0200293		
Date Assigned:	10/15/2015	Date of Injury:	12/12/2006
Decision Date:	11/24/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/13/2015

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: North Carolina
 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 65 year old male who sustained an industrial injury on 12-12-06. Subjective complaints (8-26-15) include increased neck, shoulder pain and low back pain. Objective findings (8-26-15) include right-left shoulder abduction 136-150 degrees, sore in both shoulders, neck flexion is 77 degrees and extension is 0 degrees, tender back, and is showing more pain in getting up from standing in the back. It is noted that because of the increased back pain and pain in the left knee and because his MRIs "are stale" and appears his condition has progressed, worsened, updated MRIs of the cervical spine, lumbar spine and left knee are ordered for comparison with prior MRIs. A request for authorization is dated 9-14-15. An orthopedic second opinion consultation for lumbar spine, and supportive psychiatric treatment re-evaluation was approved on 9-18-15. The requested treatment of cervical spine MRI, lumbar spine MRI, and left knee MRI was denied on 9-18-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical spine MRI #1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: 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. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore criteria have not been met for imaging of the neck and the request is not medically necessary.

Lumbar spine MRI #1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Indications for imaging, MRI.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.

Left knee MRI #1: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Indications for imaging, MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on knee complaints and imaging states: Most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. The provided physical exam for review show no knee instability or significant reduction in range of motion. There are no red flags present on exam. Therefore the request is not medically necessary.