

Case Number:	CM15-0028655		
Date Assigned:	02/20/2015	Date of Injury:	12/28/2014
Decision Date:	04/07/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/17/2015

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: Utah, Arkansas
 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 57 year old male, who sustained an industrial injury on December 28, 2014. The injured worker had reported a back injury. The diagnoses have included cervical intervertebral disc disorder without myelopathy, rotator cuff syndrome of the right shoulder and thoracic and lumbosacral neuritis or radiculitis. Treatment to date has included pain medication and a Urine Drug Screening. Current documentation dated January 6, 2015 notes that the injured worker complained of bilateral sacroiliac joint pain, buttock pain, bilateral lower extremity pain, right cervical pain and right arm pain. The pain was rated a seven out of ten on the Visual Analogue Scale. Physical examination revealed pain and a decreased range of motion of the cervical spine, lumbar spine and shoulders. On January 20, 2015 Utilization Review non-certified a request for an MRI of the right shoulder, MRI of the cervical spine and MRI of the lumbar spine. The MTUS, ACOEM Guidelines, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9 - Shoulder Complaints, Special Studies, pages 207-208.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI shoulder. According to the clinical documents, the patient does not meet criteria for a shoulder MRI including, but not limited to, red flag symptoms, neurological dysfunction, failure to progress a strengthening program intended to avoid surgery or clarification of the anatomy prior to a surgical procedure. According to the clinical documentation provided and current MTUS guidelines; MRI shoulder is not indicated as a medical necessity to the patient at this time.

MRI of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI of the cervical spine. Guidelines recommend MRI if there is a Failure of conservative treatment. According to the clinical documents, there is no report that the patient has tried and failed conservative therapy. The clinical documents lack documentation that the patient has met these criteria. According to the clinical documentation provided and current MTUS guidelines; MRI, as written above, is not indicated as a medical necessity to the patient at this time.

MRI of Lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Chapter 12, Low Back Pain, Page 305.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI of the lumbar spine. MTUS guidelines state the following: Despite the lack of strong medical evidence supporting it, diskography, including MRI, is fairly common, and when considered, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration. Failure of conservative treatment. Satisfactory results from detailed psychosocial assessment. (Diskography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.). Is a candidate for surgery. Has been briefed on potential risks and benefits from diskography and surgery. The clinical documents lack documentation that the patient has met these criteria.

According to the clinical documentation provided and current MTUS guidelines; MRI, as written above, is not indicated as a medical necessity to the patient at this time.