

<b>Case Number:</b>	CM15-0213818		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### CLINICAL CASE SUMMARY

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

This 35 year old male sustained an industrial injury on 3-19-13. Documentation indicated that the injured worker was receiving treatment for lumbago, thoracic spine sprain and strain and right shoulder impingement. Previous treatment included physical therapy and medications. In PR-2's dated 4-21-15, 6-9-15 and 8-4-15 the injured worker complained of pain in the low back, right shoulder, right arm and right leg associated with tingling and weakness in both arms and legs, rated 7 out of 10 on the visual analog scale. The injured worker reported that the pain in his arm was 70% of his pain, back 70% of his pain and leg 60% of his pain. Physical exam was remarkable for cervical spine with tenderness to palpation over the right trapezius, levator scapulae and rhomboids, lumbar spine with tenderness to palpation over bilateral paraspinal musculature and range of motion: flexion 60 degrees, extension 25 degrees and bilateral side bending 20 degrees, right shoulder with tenderness to palpation and range of motion forward flexion 120 degrees, abduction 110 degrees, external rotation 60 degrees and internal rotation 70 degrees with 5 out of 5 bilateral upper extremity strength. In an office visit dated 10-10-15, the injured worker's complained of pain in the neck, mid back, low back, right shoulder and right leg, rated 7 out of 10. Physical exam was unchanged. The treatment plan included magnetic resonance imaging thoracic spine and right shoulder, electromyography and nerve conduction velocity test of bilateral lower extremities and a prescription for Anaprox, Gabapentin, Cyclobenzaprine and Tramadol ER. On 10-22-15, Utilization Review noncertified a request for magnetic resonance imaging thoracic spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (magnetic resonance imaging), thoracic spine without dye:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** This claimant was injured two years ago, with treatment for low back pain, thoracic spine strain and right shoulder impingement. There is pain described, but no objective neurologic signs noted referent to the thoracic region. The MTUS does not specifically address thoracic imaging, but it does address back imaging in general. Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note, "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. The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended for injuries that are more acute; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Back Procedures section: Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000); Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome." These criteria are also not met in this case; the request is not medically necessary under the MTUS and other evidence-based criteria.