

Case Number:	CM15-0039068		
Date Assigned:	03/09/2015	Date of Injury:	09/21/2013
Decision Date:	04/17/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	03/02/2015

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: California
 Certification(s)/Specialty: Internal 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:

The injured worker is a 65-year-old male, who sustained an industrial injury on September 21, 2013. He has reported neck pain, left shoulder pain, left elbow pain, left wrist pain, and lower back pain. Diagnoses have included cervical spine disc displacement, left wrist carpal tunnel syndrome, lumbar spine disc displacement, lateral epicondylitis, and derangement of the shoulder joint. Treatment to date has included medications, physical therapy, and imaging studies. A progress note dated January 8, 2015 indicates a chief complaint of neck pain radiating to the bilateral arms, left shoulder pain radiating to the arm and fingers, lower back pain, and left elbow and wrist pain. The treating physician documented a plan of care that included medications, magnetic resonance imaging of the cervical spine, magnetic resonance imaging of the left shoulder, magnetic resonance imaging of the left elbow, magnetic resonance imaging of the left wrist, magnetic resonance imaging of the lumbar spine, physical therapy, acupuncture, shockwave therapy and injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) MRI (magnetic resonance imaging).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses wrist MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints Table 11-6 Ability of Various Techniques to Identify and Define Forearm, Wrist, and Hand Pathology (Page 269) indicates that magnetic resonance imaging (MRI) has nil ability to identify and define ligament and tendon strain, tendinitis, and tenosynovitis. Official Disability Guidelines (ODG) indicates that repeat MRI is not routinely recommended. Official Disability Guidelines (ODG) indicate that plain film X-rays should be performed before consideration of MRI. MRI magnetic resonance imaging of the left wrist dated 7/29/14 demonstrated scaphoid and lunate subchondral cysts. The alignment of the wrist joint was normal. The triangular fibrocartilage complex appears unremarkable. The extensor and flexor tendons appear normal. The tendons in the carpal tunnel are normal. The primary treating physician's progress report dated 1/8/15 documented a diagnosis of left carpal tunnel syndrome. The 7/29/14 left wrist MRI was not referenced. No new left wrist injury was reported. No rationale for a repeat left wrist MRI was presented in the 1/8/15 progress report. The request for a left wrist MRI is not supported. Therefore, the request for MRI of the left wrist is not medically necessary.

MRI of the left elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34, 42. Decision based on Non-MTUS Citation ACOEM 3rd Edition Elbow disorders (2012) <http://www.guideline.gov/content.aspx?id=38447>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition Chapter 10 Elbow Complaints recommends MRI for suspected ulnar collateral ligament tears, but not other elbow conditions. MRI for epicondylalgia is not recommended. ACOEM 3rd Edition indicates that magnetic resonance imaging MRI for routine evaluation of acute, subacute, or chronic elbow joint pathology, including degenerative joint disease is not recommended. MRI magnetic resonance imaging of the left elbow dated 7/29/14 demonstrated common extensor tendinosis consistent with lateral epicondylitis and triceps tendinosis. The primary treating physician's progress report dated 1/8/15 documented a diagnosis of left elbow lateral epicondylitis. The left elbow demonstrated palpation at the lateral epicondyle. Range of motion of the left elbow was normal. The 7/29/14 left elbow MRI was not referenced. No new left elbow injury was reported. No rationale for a repeat left elbow MRI was presented in the

1/8/15 progress report. ACOEM 3rd Edition indicates that MRI for routine evaluation of chronic elbow joint pathology is not recommended. The request for elbow MRI is not supported by ACOEM and ODG guidelines. Therefore, the request for MRI of the left elbow is not medically necessary.

MRI of the 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): 303-304, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses magnetic resonance imaging MRI of the lumbosacral spine. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that 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). Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308-310) recommends MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. MRI magnetic resonance imaging of the lumbar spine dated 7/29/14 demonstrated disc protrusions at L2-3, L3-4, L4-5, and L5-S1. The primary treating physician's progress report dated 1/8/15 documented a low back complaints. No evidence of cauda equina, tumor, infection, or fracture was documented. The 7/29/14 lumbar spine MRI was not referenced. No new lumbosacral spine injury was reported. No rationale for a repeat lumbar spine MRI was presented in the 1/8/15 progress report. The request for repeat lumbar spine MRI is not supported. Therefore, the request for MRI of the lumbar spine is not medically necessary.

MRI of the left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 209, 212-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Magnetic resonance imaging (MRI).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses shoulder MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints state that relying only on imaging studies to evaluate the source of shoulder symptoms carries a significant risk of diagnostic confusion (false-positive test results). MRI is recommended for preoperative evaluation of rotator cuff tears. Routine MRI without surgical indications is not recommended. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) state that there were high rates of inappropriate examinations for shoulder MRIs in patients with no histories of trauma and

documented osteoarthritis on plain-film radiography. Indications for imaging magnetic resonance imaging (MRI) include acute shoulder trauma, suspected rotator cuff tear/impingement, with normal plain radiographs. MRI magnetic resonance imaging of the left shoulder dated 7/29/14 demonstrated supraspinatus and infraspinatus tendinosis and possible partial thickness tearing. Acromioclavicular joint hypertrophy causes impingement on the supraspinatus. No other significant findings were noted. The primary treating physician's progress report dated 1/8/15 documented a shoulder complaints. The 7/29/14 left shoulder MRI was not referenced. No new left shoulder injury was reported. No rationale for a repeat left shoulder MRI was presented in the 1/8/15 progress report. The request for repeat MRI of the left shoulder is not supported. Therefore, the request for MRI of the left shoulder is not medically necessary.