

<b>Case Number:</b>	CM15-0042912		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	05/16/2014
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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 35 year old male, who sustained an industrial injury on 5/16/2014. He has reported a beam falling onto the right shoulder subsequently injury the right arm and the back down to right gluteus. The diagnoses have included cervical myospasm, cervical radiculopathy, lumbar disc protrusion, lumbar myospasm, right shoulder myofascitis and right shoulder sprain. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and chiropractic therapy. Currently, the Injured Worker complains of pain in the right shoulder, neck, low back, right wrist/hand. The physical examination from 1/30/15 documented decreased Range of Motion (ROM) and positive impingement test in right shoulder, with weakness noted. There was decreased sensation C6-7 dermatome. The plan of care included Magnetic Resonance Imaging (MRI) for right shoulder, orthopedic referral, electromyogram for right upper extremity, and activity restriction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-178; 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck 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 the 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 the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-178; 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 back. MTUS guidelines state the following: Despite the lack of strong medical evidence supporting it, discography, 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. (Discography 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 discography 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.