

Case Number:	CM15-0054915		
Date Assigned:	03/30/2015	Date of Injury:	02/14/2000
Decision Date:	05/14/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/23/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 62-year-old male who reported an injury on 02/14/2000. The mechanism of injury involved cumulative trauma. The current diagnoses include musculoligamentous strain of the cervical spine, status post C5-7 fusion, status post arthroscopic surgery to the right shoulder, impingement syndrome of the left shoulder, lumbar radiculopathy, and nonorthopedic complaints. The injured worker presented on 02/12/2015 for a follow-up evaluation. The injured worker noted complaints of cervical spine pain, bilateral shoulder pain, and lumbar spine pain. The injured worker was also followed by separate physicians for abdominal pain and psychiatric issues associated with fibromyalgia. The current medication regimen includes Motrin, temazepam, Effexor, Ambien, Lyrica, amitriptyline, and Zantac. Upon examination of the cervical spine, there was limited range of motion, tenderness to palpation from C1-7, paravertebral muscle spasm, bilateral trapezius tenderness, and tenderness in the scapular region. The examination of the left shoulder revealed tenderness in the acromioclavicular joint, subacromial bursa, and in the direction of the rotator cuff. Range of motion was documented at 95 degrees abduction and 30 degree internal rotation. Impingement and Hawkins signs were positive. The examination of the right shoulder also revealed subacromial tenderness with 120 degrees abduction, 40 degree internal rotation, and a positive impingement sign. Upon examination of the lumbar spine, there was tenderness to palpation, limited range of motion, paresthesia in the L4-S1 region, tenderness in the sciatic nerve, and 3/5 motor weakness in the bilateral lower extremities. Recommendations at that time included an updated MRI of the cervical and lumbar spine and left shoulder. The provider also recommended a course of

physical therapy twice per week for 6 weeks and a corticosteroid injection for the left shoulder. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. In this case, there was no mention of a recent attempt at any conservative management prior to the request for an additional imaging study. There was no evidence of a progression or worsening of symptoms or physical examination findings to support the necessity for a repeat MRI. Given the above, the request is not medically necessary.

Magnetic resonance imaging (MRI) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there was no documentation of a worsening or progression of symptoms or physical examination findings. There was also no documentation of a recent attempt at any conservative management prior to the request for a repeat imaging study. As the medical necessity has not been established, the request is not medically necessary.

Magnetic resonance imaging (MRI) of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. In this case, there was no documentation of a recent attempt at any conservative treatment prior to the request for an additional imaging study. There was no documentation of a significant change or worsening of symptoms or physical examination findings to support the necessity for a repeat imaging study. Given the above, the request is not medically necessary at this time.

Corticosteroid injections to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection may be indicated after conservative therapy for 2 to 3 weeks. In this case, there was no documentation of a recent attempt at any conservative management prior to the request for a corticosteroid injection to the left shoulder. In addition, there was no documentation of a significant functional limitation. Given the above, the request is not medically necessary.