

<b>Case Number:</b>	CM15-0059911		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	08/28/2013
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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: California

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 33 year old male who sustained an industrial injury on 08/28/2013. Diagnoses include sprain/strain of the thoracic region, left intercostal neuritis, rule out thoracic disc herniation and internal chest lesion. Treatment to date has included diagnostic studies, medications, physical therapy, acupuncture and chiropractic treatment. A recent physician progress note dated 02/23/2015 documents the injured worker has pain of the left rib area radiating from the front to the back, and quantified the pain as 100% in the back and left ribs. He has aching of the left side of the mid back and left ribs, and has burning sensations of the left side of the mid back and tightness of the left ribs. His overall pain intensity is 7 on a scale of 10. Bilateral shoulder range of motion and thoracolumbar spine range of motion is restricted. Treatment requested is for Magnetic Resonance Imaging of the chest/spine without dye to rule out thoracic spine disc herniation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic Resonance Imaging of the chest/spine without dye:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-7.

**Decision rationale:** Regarding the request for chest/spine MRI, CA MTUS and ACOEM guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure after failure of conservative treatment. Within the documentation available for review, the provider notes a desire to rule out disc herniation of the thoracic spine, but the patient's rib pain radiating from front to back is not consistent with such a lesion. In light of the above issues, the requested chest/spine MRI is not medically necessary.