MAXIMUS Federal Services

Case Number:	CM15-0082518		
Date Assigned:	05/04/2015	Date of Injury:	03/16/2011
Decision Date:	07/14/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/29/2015

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, Illinois
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:

The injured worker is a 55 year old female, who sustained an industrial injury on 03/16/2011. She has reported subsequent neck, back, bilateral wrist and bilateral shoulder pain and was diagnosed with cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat. In a progress note dated 03/11/2015, the injured worker complained of severe neck, back, bilateral shoulder and wrist pain. Objective findings were notable for positive shoulder impingement signs, positive Phalen's sign of the bilateral wrists and spasms and decreased range of motion of the cervical and lumbar spine. A request for authorization of MRI of the lumbar and cervical spine, bilateral shoulders and EMG/NCV of the bilateral upper extremities was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI w/o contrast 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, Low Back Chapter (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Low Back - Lumbar & Thoracic (Acute & Chronic)MRIs (magnetic resonance imaging).

Decision rationale: The injured worker sustained a work related injury on to 03/16/2011. The medical records provided indicate the diagnosis of cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat.The medical records provided for review do not indicate a medical necessity for MRI w/o contrast of the Lumbar Spine. The medical records indicate the injured worker had similar test in 2012, the records do not indicate the injured worker has progressive neurological deficit, nor physical findings of radiculopathy. The MTUS is silent on repeat MRI, but recommends against over reliance on imaging. The Official Disability Guidelines recommends against repeat Imaging except in cases of significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation. Therefore, the request is not medically necessary.

MRI w/o contrast 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, Neck and Upper Back Chapter (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Neck and Upper Back (Acute & Chronic)Magnetic resonance imaging (MRI).

Decision rationale: The injured worker sustained a work related injury on to 03/16/2011. The medical records provided indicate the diagnosis of cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat.The medical records provided for review do not indicate a medical necessity for MRI w/o contrast of the Cervical Spine. The medical records indicate the injured worker had similar test in 2012, the records do not indicate the injured worker has progressive neurological deficit, nor physical findings of radiculopathy. The MTUS is silent on repeat MRI, but recommends against over reliance on imaging. The Official Disability Guidelines recommends against repeat Imaging except in cases of significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation. Therefore, the request is not medically necessary.

MRI w/o contrast of the Right 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, Shoulder Chapter (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Magnetic resonance imaging (MRI).

Decision rationale: The injured worker sustained a work related injury on to 03/16/2011. The medical records provided indicate the diagnosis of cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat. The medical records provided for review do not indicate a medical necessity for MRI w/o contrast of the Right Shoulder. The medical records indicate the injured worker had similar test in 2012. Though the medical records indicate the injured worker has impingement, the MTUS states that cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Furthermore, the Official Disability Guidelines recommends against repeat Imaging except in cases of significant change in symptoms and/or findings suggestive of significant pathology. Therefore, the request is not medically necessary.

MRI w/o contrast 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, Shoulder Chapter (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Magnetic resonance imaging (MRI).

Decision rationale: The injured worker sustained a work related injury on to 03/16/2011. The medical records provided indicate the diagnosis of cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat. The medical records provided for review do not indicate a medical necessity for MRI w/o contrast of the Left shoulder. The medical records indicate the injured worker had similar test in 2012. Though the medical records indicate the injured worker has impingement, the MTUS states that cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Furthermore, the Official Disability Guidelines recommends against repeat Imaging except in cases of significant change in symptoms and/or findings suggestive of significant pathology. Therefore, the request is not medically necessary.

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 328, table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, Chronic Pain Treatment Guidelines Chronic Pain Discussion Page(s): 6.

Decision rationale: The injured worker sustained a work related injury on to 03/16/2011. The medical records provided indicate the diagnosis of cervical and lumbar radiculitis, rule out carpal tunnel syndrome of the bilateral wrists and rule out bilateral shoulder rotator cuff tears. Treatment to date has included oral pain medication and application of heat. The medical records provided for review do not indicate a medical necessity for EMG/NCV of the bilateral upper extremities. The medical records indicate the injured worker is complaining of bilateral wrist pain associated with tingling, numbness and weakness; the physical examination revealed positive phalen's sign in the bilateral upper limbs. The injured worker was not on medications, and the records did not provide any information regarding past treatment. The MTUS recommends that the future management of the occupational medicine patient be based on the information from thorough history, including review of medical records, previous tests and treatments; and thorough physical examination. Therefore, the requested treatment is not medically necessary due to the lack of documentation of past treatment and treatment outcome. Therefore, the requested treatment is not medically necessary.