

Case Number:	CM15-0105337		
Date Assigned:	06/09/2015	Date of Injury:	12/05/2014
Decision Date:	07/10/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/01/2015

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: 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 38-year-old male, who sustained an industrial injury on December 5, 2014. Treatment to date has included medications and work restrictions. Currently, the injured worker complains of pain in the cervical spine, the thoracic spine, the lumbar spine and the bilateral shoulders. He rates the pain a 6-7 on a 10-point scale. On physical examination, his cervical spine range of motion and his thoracic spine range of motion are within normal limits and his bilateral shoulder and lumbar spine range of motion is limited in scope. He exhibits tenderness to palpation of the cervical, thoracic, lumbar and bilateral shoulders. The diagnoses associated with the request include cervical musculoligamentous injury, cervical sprain/strain, thoracic degenerative disc disease, thoracic myofascitis, thoracic sprain/strain, lumbar degenerative disc disease, lumbar myospasm, lumbar sprain/strain, right shoulder sprain/strain, left shoulder myoligamentous injury and left shoulder sprain/strain. The treatment plan includes cold/heat therapy, TENS unit, MRI of the cervical spine, thoracic spine, lumbar spine, left shoulder and right shoulder, acupuncture therapy, chiropractic therapy, shockwave therapy for the left and right shoulder and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

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

Decision rationale: Per the MTUS Guidelines, if physiologic evidence indicates tissue insult or nerve impairment, an MRI may be necessary. Other criteria for special studies are also not met, such as emergence of a red flag, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Per available documentation, an EMG of upper and lower extremities was conducted but the results were not available for review. The request for MRI of the cervical spine is determined to not be medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297, 303, 304, 309.

Decision rationale: The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. Per available documentation, there was an EMG of the bilateral upper and lower extremities conducted, but results were not available for review. There is no objective evidence of radiculopathy or other red flags to necessitate an MRI. There is also no evidence of conservative treatments that have failed. The request for MRI Lumbar Spine is determined to not be medically necessary.

MRI Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

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

Decision rationale: Per the MTUS Guidelines, the criteria for ordering imaging studies of the shoulder include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The clinical documents provided do not indicate that any of these criteria are met. The requesting provider does not document reasoning to support a request for MRI outside these guideline recommendations. The request for MRI Left Shoulder is determined to not be medically necessary.