

Case Number:	CM15-0013443		
Date Assigned:	02/02/2015	Date of Injury:	04/04/2014
Decision Date:	05/11/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/23/2015

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: Montana

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 41 year old female, who sustained an industrial injury on 4/4/2014. The current diagnoses are cervical disc herniation with stenosis, cervical radiculopathy, thoracic and lumbar sprain/strain, bilateral shoulder bursitis, AC arthritis and impingement. According to the progress report dated 12/1/2014, the injured worker complains of persistent neck and back pain. The pain is rated 5-6/10 on a subjective pain scale. She reports occasional numbness and tingling down both arms to the level of her hands, right worse than left. Additionally, she reports occasional headaches in her posterior head and neck region associated with numbness and tingling on the sides of her head. The current medications are Norflex, Naproxen, and Prilosec. Treatment to date has included medication management, MRI studies, electrodiagnostic testing, physical therapy sessions for the spine and shoulders, home exercise program, and chiropractic treatment. The plan of care includes MRI of the thoracic and lumbar regions, orthopedic follow-up for the left shoulder, 8 additional chiropractic sessions for the cervical and lumbar regions, and follow-up in 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the thoracic and lumbar regions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304 and 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, MRI.

Decision rationale: The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery and option. Indiscriminate imaging will result in falls false positive finding such as disc bulges that are not the source of painful symptoms and do not warrant surgery. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion because of the overall false positive rate of 30%. The ODG guidelines document that MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. Indications (ODG) for Magnetic resonance imaging (MRI): Thoracic spine trauma: with neurological deficit. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection, other red flags. Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery. Uncomplicated low back pain, cauda equina syndrome. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, stepwise progressive. Myelopathy, slowly progressive. Myelopathy, infectious disease patient. Myelopathy, oncology patient. In this case there is no documentation of spinal trauma or myelopathy with neurologic deficit that represents a significant change in symptoms or findings suggestive of significant pathology that would meet the criteria for a repeat lumbar MRI. In this case there are no documented thoracolumbar radicular complaints, weakness or motor deficits. There does not appear to be any consideration for surgery. No red flag conditions are noted and there is no evidence for or diagnosis of myelopathy. There is no history of direct trauma to the thoracic or lumbar areas. The request for MRI of the lumbar and thoracic spine without documentation of progressive neurologic deficit is not medically necessary.

Orthopedic follow-ups for the shoulder: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127 Official Disability Guidelines (ODG) Shoulder, Office visits.

Decision rationale: The MTUS in the ACOEM guidelines notes that the practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The

consultation service to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. The ODG guidelines note that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case the primary treating physician is an orthopedic spine specialist. Orthopedic care has been provided for the shoulder complaints not treated by the spine specialist. The orthopedist is providing the treatment for the shoulder conditions which are not yet placed at MMI. Ongoing office visits play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The request for orthopedic follow-ups for the shoulder is medically necessary.