

Case Number:	CM15-0177817		
Date Assigned:	09/18/2015	Date of Injury:	03/27/2013
Decision Date:	10/28/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	09/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 42-year-old female who sustained an industrial injury March 27, 2013. Diagnoses have included left shoulder sprain or strain, lumbar spine strain or sprain, lumbar disc protrusions, lumbar spondylosis and facet arthritis, and lumbar myofascial spasms. She has been presenting with increased shoulder pain, and low back pain. Documented treatment includes home exercise; and, medications including Relafen, Percocet and Oxycontin which are stated to have helped in improving her ability to perform activities of daily living. The injured worker continues to report low back pain rated as 9 out of 10 with characteristics of being dull, shooting, and having spasms. The physician noted that she had positive lumbar facet loading and he observed spinal tenderness over the bilateral paravertebral muscles and bilateral sacroiliac joints. Lumbar range of motion was stated to be decreased in all planes. He also noted slow ambulation with guarded gait. Her last MRI for the lower back was in 2013. July 6, 2015 the treating physician states the injured worker had previously presented February 23, 2015 with left shoulder pain radiating down her forearm, with numbness tingling. The objective examination revealed tenderness over the subacromial and acromioclavicular joint, supraspinatus tendon, and parascapular region with a positive impingement test. Additionally, there was weakness with flexion and abduction with "decreased range of motion" in all planes. They are considering physical therapy, but the treating physician's plan of care associated with this request for authorization includes MRI of the lumbar spine with gadolinium, epidural injection, and follow up with a pain management and rehabilitation specialist for the left shoulder. All were denied on August 5, 2015. Current work status has been temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine with gadolinium: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. 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 (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging, Magnetic resonance imaging: 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; Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The documentation submitted for review indicates that the injured worker previously had MRI of the lumbar spine 6/2013, however, it was not available for review. Per progress report dated 6/29/15 it was noted that the injured worker's low back pain is isolated and does not radiate down the lower extremity. She was not experiencing any lower extremity paresthesias or weakness. There was 5/5 strength in the lower extremities, and neurologically intact testing bilaterally in the lower extremities. Absent any red flag findings, repeat MRI is not medically necessary.

Epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Per progress report dated 6/29/15 it was noted that the injured worker had 5/5 upper extremity strength with intact reflexes and sensation. It was noted that the plan was for the injured worker to participate in physical therapy after an epidural injection in the cervical region. The documentation submitted for review does not contain physical exam findings of radiculopathy or clinical evidence of radiculopathy. MRI of the cervical spine dated 3/26/15 did not reveal any evidence of stenosis. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria is not met, the request is not medically necessary. Furthermore, the request does not specify a level.

Follow up with a PM and R specialist for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: The California MTUS Guidelines recommend a consultation to aid with diagnosis/prognosis and therapeutic management, recommend referrals to other specialist if a diagnosis is uncertain or exceedingly complex when there are psychosocial factors present, or when, a plan or course of care may benefit from additional expertise. The medical necessity of the requested referral has not been sufficiently established by the documentation available for my review. Per progress report dated 6/29/15 it was noted that the injured worker was experiencing numbness and tingling primarily in the left upper extremity. She also felt weak and stiff. There was no evidence of conservative treatment for the shoulder. As such, the request is not medically necessary.