

Case Number:	CM15-0091656		
Date Assigned:	05/18/2015	Date of Injury:	04/27/2011
Decision Date:	06/25/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/12/2015

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, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 67 year old male who sustained an industrial injury on 04/27/11. Initial complaints and diagnoses are not available. Treatments to date include medications ad home exercises. Diagnostic studies include x-rays of the cervical spine, right shoulder, elbow, and forearm. In a progress note dated 03/12/15 the treating provider reports the plan of care as medications including Lodine and Tylenol, home exercises, chiropractic treatment, and a MRI of the cervical spine. The requested treatments include MRIs of the cervical and thoracic spines and the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical R/O HNP: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck, MRI.

Decision rationale: The patient presents with pain affecting the right shoulder, and neck with radiation into the bilateral upper extremities. The current request is for MRI Cervical R/O HNP. The treating physician report dated 1/29/15 (11B) states, "Pt states his (right) shoulder is having increased pain that radiates up into his neck and (bilateral upper extremities)." The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding MRIs of the cervical spine: "Not recommended except for indications list below." The guidelines go on to state, Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. The medical reports provided, do show that the patient has received 2 x-rays of the cervical spine but the dates and results were not discussed in the documents provided for review. In this case, while the patient does present with at least 3 months of chronic neck pain, the ODG guidelines require much more documentation to recommend an MRI of the cervical spine. Furthermore, there was no documentation of any neurological findings to indicate that radiculopathy is present. The current request is not medically necessary and the recommendation is for denial.

MRI Right Shoulder R/O Internal Derangement: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, MRI.

Decision rationale: The patient presents with pain affecting the right shoulder, and neck with radiation into the bilateral upper extremities. The current request is for MRI Right Shoulder R/O Internal Derangement. The treating physician report dated 1/29/15 (11B) states, "Pt states his (right) shoulder is having increased pain that radiates up into his neck and (bilateral upper extremities)." The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding MRIs of the shoulder: "Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific." The guidelines go on to state, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." The medical reports provided, note that an "MRI scan did reveal a rotator cuff tear and surgery was undertaken by (treating physician) on 4/27/14." In this case, the patient has received at least 2 prior X-rays of the right shoulder and at least one MRI. There was no rationale by the physician in the documents provided that suggest the patient's symptoms or pathology has dramatically changed since the patient's last MRI. The current request is not medically necessary as repeat MRIs are only supported by the ODG guidelines if there is documentation of a significant change in symptoms or pathology. Furthermore, there was no rationale by the treating physician as to why the patient requires a repeat MRI in the medical reports provided, and the dates and findings of the patient's previous radiographs were not provided for review. The request is not medically necessary. Recommendation is for denial.

MRI Thoracic R/O HNP: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Upper Back, MRI.

Decision rationale: The patient presents with pain affecting the right shoulder, and neck with radiation into the bilateral upper extremities. The current request is for MRI Thoracic R/O HNP. The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding MRIs of the thoracic spine: "Not recommended except for indications list below." The guidelines go on to state, Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. The medical reports provided, do show that the patient has received 2 x-rays of the thoracic spine but the dates and results were not discussed in the documents provided for review. In this case, while the patient does present with at least 3 months of chronic upper back pain, the ODG guidelines require much more documentation to recommend an MRI of the thoracic spine. Furthermore, there was no rationale by the physician as to why the patient requires an MRI in the medical reports provided. The request is not medically necessary. Recommendation is for denial.