

Case Number:	CM15-0096273		
Date Assigned:	05/26/2015	Date of Injury:	10/01/2007
Decision Date:	06/26/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/19/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 58 year old female sustained an industrial injury to the neck, back, right wrist and right shoulder on 10/9/07. Previous treatment included magnetic resonance imaging, physical therapy, injections, transcutaneous electrical nerve stimulator unit, home exercise and medications. No recent diagnostic studies were provided for review. In a PR-2 dated 4/7/15, the injured worker reported that she had noticed a burning sensation down her hips. The injured worker reported that her neck had good and bad days especially with weather changes. The injured worker stated that her cervical and thoracic spine pain radiated into her shoulder. X-rays of the right shoulder, right humerus and bilateral clavicles showed not acute changes. Physical exam was remarkable for lumbar spine with tenderness to palpation, muscle spasms, decreased range of motion, good heel and toe walk, positive straight leg raise, no gross instability and no acute neurologic changes and right shoulder with positive impingement and nearly symmetrical range of motion. Current diagnoses included cervical spine, lumbar spine and thoracic spine foraminal stenosis with bilateral radiculopathy, bilateral sciatica, right shoulder sprain/strain with possible internal derangement and right wrist contusion with possible internal derangement. The treatment plan included physical therapy three times a week for six weeks, medications (Tylenol and Lodine), magnetic resonance imaging of the right wrist, right shoulder, bilateral hips as well as magnetic resonance imaging of the cervical spine, thoracic spin and lumbar spine to rule out herniated nucleus pulposus.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI (magnetic resonance imaging), Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter Indications for magnetic resonance imaging (MRI).

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

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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 an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not certified.