

Case Number:	CM13-0022826		
Date Assigned:	06/06/2014	Date of Injury:	02/14/2011
Decision Date:	07/14/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/11/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 44-year-old male who reported an injury on 02/14/2011, due to being attacked by a bull. The injured worker remained conscious and engaged with the bull during the 20-25 minute attack, defending himself with an electric cattle prod. The physician noted a right knee contusion and right chest contusion. After the examination of the injured worker, he received the following diagnoses; head trauma with post-concussion syndrome and status post right knee surgery times two (2). The provider recommended a psychological evaluation. The injured worker received Tylenol with codeine for pain and was sent home. On 02/16/2011, he returned to the doctor complaining of low back pain, rated 7-8/10. The physician ordered ice packs applied to the affected area and the use of crutches to ambulate. On 02/17/2011, the injured worker returned to the physician with the same complaints and was told to continue medications. On 03/18/2011, an MRI of the lumbar spine revealed no disc herniation. On 09/13/2011, an MRI of the cervical spine indicated that there was mild multilevel degeneration disease of the cervical spine with minimal central disc osteophyte complex seen at C4-C5 through C7-T1. There was no central canal or neural foraminal stenosis. The spinal cord registered normal in signal intensity and morphology. On 03/12/2013, the injured worker had a negative Spurling's and negative Lhermitte's test. The injured worker had a negative straight leg raise test, negative Babinski's test, negative Hoffman's, negative Fabere's test and negative Clonus test. The physician noted restricted range of motion to the cervical and lumbar spine and tenderness to the paraspinal muscles during the exam. On 11/21/2013, an electromyography and nerve conduction velocity study were performed which revealed minimal evidence for right C6 nerve root irritation. There was no complaint of pain to that site unless palpated or stimulated with motion or manipulation. A request for authorization form for MRI of the cervical and lumbar spine was submitted for review and signed on 03/18/2013. The provider recommended

the cervical and lumbar spine MRI's due to a lack of improvement in function and pain as well as a decline in mental status.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT MRI OF THE CERVICAL AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Neck and Upper Back for MRI.

Decision rationale: The Official Disability Guidelines indicate that a repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology, such as tumor, infection, fracture, neurocompression, and recurrent disc herniation. During the attack, the injured worker never lost consciousness and neurological tests indicated that nerve damage and trauma to the cervical spine was negative. The confirmation of myelopathy is the primary diagnostic value to an MRI to the lumbar section; this was never established during neurological exams performed by physicians. Within the provided documentation, there is lack of physical exam findings including decreased sensation, decreased strength, decreased reflexes, and a positive straight leg raise to indicate significant neurologic dysfunction in the lumbar spine. Additionally, there is a lack of documentation indicating a significant change in symptoms and/or findings suggestive of significant pathology since the previous imaging was performed to the cervical and lumbar spines. Based on these outcomes, an MRI to the cervical and lumbar spine would not be indicated at this time. Therefore, the request is not medically necessary.