

Case Number:	CM13-0038791		
Date Assigned:	12/18/2013	Date of Injury:	09/04/2006
Decision Date:	02/07/2014	UR Denial Date:	09/20/2013
Priority:	Standard	Application Received:	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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 physician 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 claimant sustained a work related injury on 09/04/2006. The mechanism of injury was not provided. His diagnoses include chronic low back pain, postlaminectomy syndrome of the lumbar spine, lumbosacral spondylosis, lumbar radiculopathy, cervical spondylosis, cervical degenerative disc disease, s/p L3-S1 fusion, 2008 and depression. On exam he complains of low back and posterior neck pain. The pain radiates down the posterolateral aspect of the right lower extremity to the foot and to both shoulders. He has restricted and painful lumbar range of motion and pain with facet loading. There is decreased sensation in the L1-S1 dermatomes on the right. He has been treated with medical therapy, surgery, acupuncture, chiropractic treatment, physical therapy, massage, behavioral therapy and radiofrequency ablation. The treating provider has requested an MRI of the thoracic spine without 3T7.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the thoracic spine without 3T7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Low Back Procedure Summary, and Canale: Campbell's Operative Orthopaedics, 10th ed. Chapter 29, Low Back Pain and Disorders of Intervertebral Discs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: There is no documentation provided necessitating an MRI of the thoracic spine. MRI is indicated if there are unequivocal objective findings that identify specific nerve compromise on neurologic examination in patients who do not respond to treatment and who would consider surgical intervention. Thoracic MRI imaging is the mainstay in the evaluation of myelopathy. In addition to diagnosing disc herniation, neoplastic or infectious pathology can be visualized. In this case there is limited evidence of sensory changes and myotomal weakness in the thoracic nerve root distribution. Medical necessity for the requested thoracic MRI has not been established. The requested service is not medically necessary.