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| Case Number: | CM13-0041331 | | |
| Date Assigned: | 12/20/2013 | Date of Injury: | 06/08/2010 |
| Decision Date: | 02/10/2014 | UR Denial Date: | 10/14/2013 |
| Priority: | Standard | Application Received: | 10/14/2013 |

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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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:

A 58-year-old male with date of injury of 06/08/2010. The request for magnetic resonance imaging (MRI) and x-ray of the spine were denied by utilization review letter dated 10/14/2013. Rationale was that the information did not include currently relevant medical information. According to report 07/31/2013 by [REDACTED], the patient presents with neck and low back pain at intensity of 8/10 and with medication, 7/10. Diagnostic impressions were cervicalgia with possible facet arthropathy, cervical spondylosis, lumbosacral sprain/strain, and lumbar spondylosis. The request was for x-ray series of the spine to evaluate his scoliosis, and magnetic resonance imaging (MRI) of the cervical spine because the patient has increasing pain and consider advanced surgical intervention if warranted. Examinations are absent for the spine. Report by [REDACTED], 06/21/2013, shows an examination with normal curvature. This report was by [REDACTED] and he listed diagnosis of multilevel degenerative disk disease and disk bulges of the lumbar spine from L3 to S1. Report by [REDACTED] from 06/26/2013 shows that the patient was referred for possible epidural steroid injection. Examination showed spasm, tenderness, and decreased range of motion of the lumbar spine. His request was for trial of lumbar epidural steroid injection x1. He noted that the patient has abnormal findings on magnetic resonance imaging (MRI) correlating with his pain pattern. He reviewed reference to an magnetic resonance imaging (MRI) stating degenerative disk disease and disk bulges at L3 to S1. He did not have the official report.â€¦

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical magnetic resonance imaging without contrast; x-ray spine scoliosis series: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: This patient presents with chronic neck and low back pain. Review of the requesting physician's report on 07/31/2013 does not provide any physical examination of the cervical spine. [REDACTED] report from 06/21/2013 shows normal curvature of the cervical spine and no neurologic deficits. Report by [REDACTED], 06/26/2013, shows spine examination of decreased range of motion of the lumbar spine with spasms and tenderness only. He notes some generalized weakness in the lower extremities and positive straight leg raise bilaterally. The request of x-ray of the spine for scoliosis is unwarranted. None of the examination show any evidence of significant scoliosis to be concerned about. American College of Occupational and Environmental Medicine (ACOEM) Guidelines page 177 to 178 shows that for ordering imaging studies, there needs to be emergency red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in strengthening program intended to avoid surgery. In this case, the treating physician does not provide any emergency red flag, physiologic evidence of tissue insult or neurologic dysfunction, none is described other than per patient's persistent pain. Recommendation is for denial.