

Case Number:	CM13-0060883		
Date Assigned:	12/30/2013	Date of Injury:	02/23/2007
Decision Date:	04/10/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/04/2013

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 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 patient is a 50-year-old female who was seen on 12/16/2013 for re-evaluation of a workrelated condition. The patient continues to describe difficulty with elevation of left arm, as well as pain in her neck, pain in the lower back, and pain referred into her right hip and leg. On physical exam, it was noted the patient has restricted range of motion of the left shoulder and pain. She has no frank motor skills in the upper extremities. The patient has some numbness in the thumb, index, and long fingers on the left side. She has some tenderness to palpation in the cervical spine. The patient also has limited range of motion in the lumbar area; positive straight leg raise at 90 degrees on the right. The physician noted the patient has no motor or sensory deficits in the lower extremities. X-rays were completed at this visit and demonstrates evidence of a consolidating arthrodesis at the newly revised fusion at C3-4 and C6-7. The physician also noted no hardware failures or collapse noted. The patient has diagnosis of the shoulder capsulitis, cervical pseudarthrosis status post revision fusion, and lower back pain with lumbar degenerative disc disease. The physician's recommendation plan of care is to move the patient into a Functional Restoration Program to help the patient compensate and develop effective living strategies to deal with her current pain with minimum narcotics.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The MTUS/ACOEM Guidelines do recommend MRI for disc protrusion, cauda equina syndrome, spinal stenosis, or post-laminectomy syndrome would be appropriate. The documentation provided does not support medical necessity for the MRI at this time and the only thing stated was the lower extremity had limited lumbar range of motion and positive straight leg raise at 90 degrees on the right. The physician also did state no motor or sensory deficits in the lower extremity. The request for a MRI of the lumbar spine is not medically necessary and appropriate.