

Case Number:	CM13-0072097		
Date Assigned:	01/08/2014	Date of Injury:	12/31/2003
Decision Date:	06/05/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	12/30/2013

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 Occupational Medicine, 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 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 65 year old male who was injured on 12/31/03. The mechanism of injury was lifting two containers of soft drinks. Prior treatment history has included epidurals and other medications. The patient's medications as of 11/14/13 included folic acid, Lisinopril 20mg twice daily, Terazosin, and Omeprazole 20mg daily. An MRI of the lumbar spine dated 6/19/10 shows a 6mm anterolisthesis of L4 on L5, possible spondylolysis at L4 and L5, and acquired canal and/or foraminal stenosis at L4-L5 and L5-S1. The same MRI also demonstrates dextroscoliosis and reversal of the cervical lordosis pivoted around C5-C6. The alignment is maintained. There are no fractures or bone or soft tissue tumors. There is no intrinsic abnormality in the cervical cord. There is no craniovertebral junction abnormality. The paravertebral musculature is unremarkable. A PR2 dated 11/14/13 indicates that the patient presents with complaints of persistent neck pain that radiates to the upper extremities with numbness and tingling. He has low back pain that is aggravated with usual activities. He indicates that his neck pain is progressively getting worse and popping is present. On exam, the cervical spine demonstrates tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling's maneuver are positive. There is painful and restricted cervical range of motion. The lumbar spine reveals tenderness from the mid to distal lumbar segments. There is pain with terminal motion and the seated nerve root test is positive. The patient walks with axillary crutches and a limp. There is dysesthesia at the L5 and S1 dermatomes. Diagnoses are cervical discopathy with radiculitis and lumbar discopathy with radiculitis, with L4-5 segmental instability and L5-S1 disc collapse. The plan is to order a new MRI of the cervical and lumbar spine to determine any interval changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The cervical MRI performed on 6/19/10 showed multilevel disc protrusions and nerve root compromise on the left at C6-7 disc level, along with facet joint arthropathy bilaterally at the C6-7 disc level. The clinic note dated 11/14/13 states that the patient's chronic neck pain is progressively worsening and involves popping. The patient's neck pain radiates to the upper extremities with numbness and tingling. No other details are provided. Cervical spine examination shows tenderness, positive Spurling's maneuver, and decreased range of motion. An MRI is requested to assess interval worsening. However, it is unclear if there has been a significant change in the patient's symptoms given lack of detail provided. There are no findings of numbness, weakness, or decreased reflexes on examination. There is no clear evidence of tissue insult or dysfunction. There are no red flag findings. As such, the request is not medically necessary.

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The lumbar MRI performed on 6/19/10 showed multilevel changes, including 6mm anterolisthesis at L4 on L5, and nerve root compromise and facet arthropathy at L4-5 and L5-S1 bilaterally. The clinic note from 11/14/13 mentions worsening low back pain that is aggravated by performing usual activities. Physical examination notes dysesthesia in the L5 and S1 dermatomes, limp, positive seated nerve root test, and painful range of motion. It is unclear if these findings represent a change from baseline. Recent lower extremity nerve conduction studies did not show evidence of radiculopathy. The patient does not appear to be a surgical candidate given cardiac comorbidity. As such, the request is not medically necessary.