MAXIMUS Federal Services

Case Number:	CM14-0183890		
Date Assigned:	11/10/2014	Date of Injury:	06/12/2014
Decision Date:	12/18/2014	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/04/2014

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 claimant was injured on 06/12/14 when he fell off a ladder. MRIs of the cervical spine and lumbar spine are under review. He saw an eye doctor on 06/20/14 and complained of double vision and possible vertigo. He felt 10-15 feet off a ladder at work and hit his head and back. He complained of monocular diplopia in both eyes. His diplopia was not consistent with objective findings and no further treatment was recommended. On 10/14/14, he was seen again. He complained of blurry vision and was getting worse over the last 4 months. Following an eye exam, he was released from care. Impression was presbyopia and hypertropia and the exam was within normal limits. He was prescribed reading glasses. He had previous MRIs of the cervical and lumbar spines that were negative. On 10/15/14, he was seen for post-concussion syndrome and complained of severe radiating pain down to his neck and bilateral shoulders, mid back, low back and bilateral hips. It occurred several times daily and the typical duration was quite variable and was worse with his activities. He had intermittent diplopia and complained of some dizziness and headaches. He had decreased range of motion of the cervical spine with spasm and stiffness. His pain was unchanged. He had a normal gait. He had pain with range of motion of his back and with walking. There were no focal neurologic changes. He was to follow-up if necessary. He was diagnosed with lumbar and thoracic compression fractures. On 09/24/14, his symptoms were the same. He was referred to an ophthalmologist for blurry vision. He also had post-concussion syndrome and was given Neurontin. On 10/22/14, he saw a neurologist. He complained of continuous headaches at level 8-9/10. This started in the mid line it radiated to both sides of his head. They were aggravated if he simply walks or if he gets out in the sun or is exposed to loud noises. He feels as if his head is going to explode. His symptoms were slightly better if he walks a little. He was only doing aquatic therapy. When he walked his low back pain got worse. He had continuous 7/10 neck pain with the right side worse than the left and it

was localized in his neck which intermittently popped. It was aggravated if he moved his neck or walked or rode in a car. His neck pain was better with massage. He was doing minimal exercise. He had 11 sessions of physical therapy. He also had a normal MRI of his head. His back had a positive axial loading test and he had inconsistent straight leg raise test. He had some tenderness over his hips. Sensation and reflexes were intact. His neck and back pain were considered musculoskeletal with possible lumbar disc herniation but doubtful cervical disc herniation. He was neurologically intact. MRIs of the neck and low back were ordered. He also had a cervical spine CT scan that showed no acute fractures or subluxations. There was possible muscle spasm.

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 on 3 Tesla Magnet: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, MRIs

Decision rationale: The history and documentation do not objectively support the request for a repeat Magnetic Resonance Imaging (MRI) of the cervical spine in the absence of clear evidence of new or progressive neurologic deficits and/or failure of a reasonable course of conservative treatment. The California Medical Treatment Utilization Schedule (MTUS) do not address repeat or post op imaging studies and the Official Disability Guidelines (ODG) state "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neurocompression, and recurrent disc herniation)." The initial MRI was normal and no focal neurologic deficits involving the cervical spine and upper extremities have been documented. He has developed no new symptoms and no new or progressive focal neurologic deficits have been documented in the file. The indications for a repeat study have not been clearly stated and none can be ascertained from the records. The claimant appears to be reasonably stable. There is no evidence that urgent or emergent surgery is being anticipated. The medical necessity of this repeat study for the cervical spine has not been demonstrated.

MRI of the lumbar spine on 3 Tesla Magnet: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, MRIs

Decision rationale: The history and documentation do not objectively support the request for a repeat Magnetic resonance imaging (MRI) of the lumbar spine in the absence of clear evidence of new or progressive neurologic deficits and/or failure of a reasonable course of treatment. The California Medical Treatment Utilization Schedule (MTUS) do not address repeat or postop imaging studies and the Official Disability Guidelines (ODG) state "repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor, infection, fracture, neurocompression, recurrent disc herniation)." The initial MRI was normal and no focal neurologic deficits involving the lumbar spine and lower extremities have been documented. He has developed no new symptoms and no new or progressive focal neurologic deficits have been documented in the file. The indications for a repeat study have not been clearly stated and none can be ascertained from the records. The claimant appears to be reasonably stable. There is no evidence that urgent or emergent surgery is being anticipated. The medical necessity of this study for the lumbar spine has not been demonstrated.