

Case Number:	CM14-0027011		
Date Assigned:	06/13/2014	Date of Injury:	07/29/2011
Decision Date:	07/16/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	03/03/2014

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 Occupational Medicine. 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 injured worker is a 48 year old male whose date of injury is 07/29/11. The mechanism of injury is not stated. He has a history of ACDF C5-6, C6-7 prior to this injury. The injured worker was seen on 09/26/13 with complaint of neck pain and medial scapular pain. He also has intermittent recurrent low back pain on the left greater than right that radiates in an S1 distribution. The injured worker manages his pain with Norco 4-5 tablets a day. On examination gait is slow; posture is normal. There is positive deep tenderness in the lumbar spine bilaterally; bilateral cervical muscle spasm right greater than left. Deep tendon reflexes were 1- bilateral biceps; 1+ right knee; 2+ left knees. Lidoderm patches versus cream were recommended. Other medications included Baclofen and Norco. He has been treated with physical therapy, facet blocks and epidural steroid injections. Medical record dated 12/16/13 noted lumbar MRI dated 09/26/13 was compared to prior study of 08/02/11 and showed a 4-5mm disc bulge at L4-5 with moderate right and left foraminal stenosis; loss of disc height at L5-S1 with 5-6mm ridging osteophyte disc bulge complex and moderate right and left neuroforaminal stenosis; non-displaced L2 vertebral body compression fracture has seen complete resolution. The injured worker was seen on 02/06/14 with complaint of neck pain, low back pain. Facet injection was noted to have resulted in back pain resolution for about a month and a half. Repeat MRI was recommended to evaluate progression of disease at l4-5, L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR SPINE WITHOUT CONTRAST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The MTUS/ACOEM Guidelines notes that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The injured worker has had prior imaging studies including MRI scans of the lumbar spine. There is no evidence of progressive neurologic deficit or objective findings that identify specified nerve compromise as demonstrated by changes in motor, sensory or reflex changes that would support the need for repeat MRI. Therefore, the request for MRI lumbar spine without contrast is not medically necessary and appropriate.